88-1659

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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CONTENTS REPRODUCED FROM FURNISHED PRETYPED COPY.

QUESTIONS PRESENTED

1. Does the Employee Retirement Income Security Act (ERISA), 29 U.S.C. Section 1001, et seq., bar plaintiffs from securing State law remedies afforded by a State law which regulates insurance, as defined in the ERISA saving clause, 29 U.S.C. Section 1144(b)(2)(A) ("...nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance...")? [1]

2a. What are the criteria which will establish that an insurance

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1. This issue is currently before this Court on a Petition for Writ of Certiorari in at least one other case we know of: Commercial Life Ins. Co. v. Superior Court (Juliano) 47 Cal.3d 473, 764 P.2d 1059 (1988), petition filed March 15, 1989, Docket No. 88-1530. As will be seen below (Section EI infra), there will doubtless eventually be numerous other petitions to this Court presenting the same issue.

arrangement is an "employee benefit plan" subject to ERISA, under 29 U.S.C. Section 1003, where, as here, there was no formal written plan? [2]

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2. The importance of this question and the necessity for its resolution by this Court have been conceded by David L. Bacon, Esq., and Adams, Duque & Hazeltine, Esqs., counsel for the respondent herein, Connecticut General Life Ins. Co. Said counsel have recently filed a petition for Writ of Certiorari in this Court in Pacific Mutual Life Ins. Co. v. Turnbow, Docket No. 88-1546. That case presents the very same question of the criteria necessary to establish an "employee benefit plan" subject to ERISA (see Petition in Pacific Mutual Life Ins. Co. v. Turnbow, "Questions Presented," at p. i). In their Petition, Messrs. Bacon and Adams, Duque & Hazeltine state that there is "An Increasingly Significant Circuit Split," on this question "And Wide-Spread Division And Error In The Lower Courts, Which Can Only Be Resolved By This Court" (Pacific Mutual Life Petition, Point II, p. 16 [emphasis added]. See also, id. at pp. 19, 26).

It is safe to predict that there will eventually be numerous other petitions filed in this Court raising this issue, in view of the uncertainty surrounding the issue of the circumstances when an insurance arrangement constitutes an "employee

(Continued on next page)

b. Where, as here, the insureds' direct employer had not established or maintained an employee benefit plan subject to ERISA, as defined by 29 U.S.C. Section 1003(a), is such a plan established by the activities of a "group or association of employers," pursuant to 29 U.S.C. Section 1002(5), where there is no evidence that the purported employer association in question was in fact a group or association of homogeneous, related employers and no evidence that the insured's direct employer had any

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benefit plan" subject to ERISA (see Point EII, infra).

The issue of the criteria necessary to establish an "employee benefit plan" subject to ERISA is one of the issues now pending before this Court in Commonwealth v. Morash, 402 Mass. 287, 552 N.E.2d 409, cert. granted, October 3, 1988, 109 S.Ct. 53.

voice in the management of the purported employer association? [3]

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3. The petitioners herein are plaintiffs-appellees THEODORE KANNE and BEATRIZ KANNE, who were insured under a group insurance policy issued by respondent, CONNECTICUT GENERAL LIFE INSURANCE COMPANY, defendant-appellant in the Court below. The KANNES and CONNECTICUT GENERAL LIFE INSURANCE COMPANY are the only parties to these proceedings.

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No.

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October Term, 1988

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v.

CONNECTICUT GENERAL LIFE INS. CO.,
RESPONDENT

PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Theodore and Beatriz Kanne respectfully petition this Court for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

A. OPINIONS BELOW

The opinion of the District Court, filed January 23, 1985, is reported at

607 F.Supp. 899 (Appendix A, annexed hereto).

The original opinion of the Court of Appeals for the Ninth Circuit was filed on June 4, 1987, and is reported at 819 F.2d 204 (Appendix B, annexed hereto). On July 23, 1987, the Court of Appeals vacated that opinion and requested briefing on two issues: whether the insurance policy in question is a plan governed by ERISA and whether California Insurance Code Section 790.03(h)(2) is preempted by ERISA. This order is reported at 823 F.2d 284.

On October 4, 1988, the Court of Appeals issued its opinion, vacating the District Court's opinion (Appendix C, annexed hereto). This opinion is reported at 859 F.2d 96. On October 18, 1988, the Kannes filed a Petition for Rehearing. On February 2, 1989, the

Court of Appeals issued an amended opinion upon denial of rehearing (Appendix D, annexed hereto). That opinion is not yet in the official reports as of this writing.

B. JURISDICTION

The opinion of the Court of Appeals vacating the District Court's judgment for petitioners was filed on October 4, 1988. The Court of Appeals modified its opinion on denial of the Kannes' petition for rehearing, on February 2, 1989, which is the date of the judgment sought to be reviewed (Appendix D, infra). The District Court entered its order vacating the judgment on March 17, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. Section 1254(1), by reason of the Court of Appeals' holding that the federal law of ERISA applies to this action, and preempts petitioners'

State law remedies.

C. STATUTES AND REGULATIONS INVOLVED IN THIS CASE

The verbatim text of the statutes and regulations involved in this case is annexed hereto as Appendix E. They are as follows: 29 U.S.C. Section 1144(b)(2)(A); 29 U.S.C. Section 1003(a); 29 U.S.C. Section 1002(5); 29 U.S.C. Section 1131; 29 CFR Section 2510.3-1(j); California Insurance Code Section 790.03(h)(2).

D. STATEMENT OF THE CASE

This action was originally filed on December 17, 1982 in the Superior Court of the State of California (Appendix A, p.2). The complaint of petitioners Theodore and Beatriz Kanne sought compensatory and punitive damages under California law against respondent Connecticut General Life Insurance Co.

(Connecticut General) and others (Appendix A, p.3). Petitioners alleged various causes of action arising out of respondent's failure to pay claims for medical benefits (ibid). On April 8, 1983, after various defendants in the case were dismissed, the case was remanded to federal court on the basis of diversity jurisdiction (28 U.S.C. Section 1332) (Appendix A, p.4).

Petitioner Theodore Kanne was an employee of Harlow Carpets (Appendix A, p.5). Respondent Connecticut General had issued a group medical insurance policy to the ABC Trust, of which Harlow Carpets was a member (ibid). On May 23, 1981, the Kannes' son, Jonathan, was born in the Netherlands two months premature (Appendix A, p.6). Because Jonathan had congestive heart failure and was cyanotic, the doctors in the Netherlands

recommended that Jonathan be treated at Moffitt Hospital in San Francisco, California (id, pp. 6-7). Pursuant to these recommendations, Jonathan was transported from the Netherlands to San Francisco by air ambulance (id, p.7).

Subsequently, petitioners incurred substantial medical bills over a period of time because of the gravity of Jonathan's condition (Appendix A, pp. 8-11). Jonathan was hospitalized after surgery for the period from October 16, 1981 to November 13, 1981 (id, p. 10). The bill for this hospitalization, in the amount of $89,840.16, was received by respondent Connecticut General on December 29, 1981, at the latest (Appendix A, at p.10). Connecticut General falsely told Mr. Kanne that it had not received the bill and used that as a pretext for not paying it (id at pp.

10-11). [4] Connecticut General paid only $9,999 on the claim in February, 1982 and $9,999 in March, 1982 (Appendix A at p.10). [5] It paid the remaining sum, totaling $69,917.44, in September and October, 1982, only after a collection agency made demand and the Kannes went to the expense of hiring an

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4. In fact, the testimony established that the bill was mailed to Connecticut General in October, 1981 (RT Vol. I, pp. 18-19, Vol. II, pp. 67-71), and that Connecticut General not only had the bill in its file, but was also repeatedly notified by a co-insurer that this bill was outstanding (RT Vol. I, pp. 63-64, Vol. II, pp. 111-115, 125, 128-9).

5. At trial, Connecticut General claimed it could not make payments of more than $9,999 at a time because its computer program could not write checks for more than four digits (RT Vol. II, p.140, lines 18-24). It also had an internal rule that it could not write more than two checks to any health care provider in any one day (RT Vol. II, p.140, line 18-p.141, line 19). Even with these artful self-imposed restrictions aimed at delaying payments, Connecticut General still could have paid the claim far more quickly than it did.

attorney (ibid).

The District Court found that "Connecticut General neither has justified the delay in these payments nor has provided any rationalization for its failure to investigate in a timely fashion the status of the $69,141.44 sum. Connecticut General knew or should have known that the sum had not been paid at least as early as December 29, 1981, when it received the balance forward indication on the $89,840.16 bill." (Appendix A, at p. 21) (emphasis added). [6]

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6. The Department of Labor regulations provide that an insurance company administering an ERISA plan is permitted to delay any decision as to whether to pay a claim for up to 300 days, by availing itself of extensions of time permitted by the regulations. 29 CFR Section 2560.503-1(e)(1)(3); Section 2560.503-1(h). Even if the 300-day provision is violated, the insurer is not

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The Kannes suffered excruciating emotional turmoil because of Connecticut General's failure to pay these bills. The Kannes feared they would not be able to secure for Jonathan the medical attention necessary for his survival (RT Vol. I, pp. 22-24, 71-76, Vol. II, p.76). Because Connecticut General didn't pay

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subject to any penalties because the only result of failure to comply is that the claim is deemed denied. See 29 CFR Section 2560.503-1(h)(4); Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 144, 105 S.Ct. 2380, 3091 (1985).

The result is that the inordinate delays in payment allowed by ERISA force health care providers to, in effect, provide interest-free loans to insurance companies. Thus, the effect of broad ERISA preemption on health care providers could well be catastrophic.

Considerations such as these impelled the California Medical Association to file an Amicus Curiae Brief in the California Supreme Court in Goodrich v. General Telephone Co. of California, S002951, and in Commercial Life Ins. Co. v. Superior Court, supra, FN 1, supra, urging that ERISA should not preempt state laws regulating insurance.

Jonathan's physicians, said physicians demanded that the Kannes pay cash for all future visits (RT Vol. I, p.24, lines 10-20, pp. 72, 76). Mrs. Kanne was therefore compelled to sneak out of the doctors' offices after visits because the Kannes couldn't pay the bills (RT Vol. I, p.24, lines 21-24). [7]

Connecticut General's delays were not caused by any dispute over whether the claims were justly due. The only claim that Connecticut General disputed was the claim for payment of the air ambulance. Connecticut General rejected this claim, assigning different professed reasons at different times (Appendix A at

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7. Mr. Hanna, the manager of Connecticut General's Los Angeles Claims Center (RT Vol. IV, p.9), testified that taking 11 months to pay a claim that was clearly due would not violate Connecticut General's standards (RT Vol. IV, p.16, line 20 to p.17, line 2).

pp. 17-18). [8]

United States District Judge Edward Rafeedie, sitting without a jury, found that Connecticut General had breached the common law duty of good faith and fair dealing (Appendix A, pp. 22-27) and also violated California Insurance Code

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8. Although Connecticut General claimed in this litigation that it was acting as an ERISA "claims review fiduciary" (see, e.g., Connecticut General's reply brief to the Court of Appeals, served January 30, 1986, at pp. 23, 36, 38), it never produced any evidence that it (or anyone else) ever complied with ERISA's claims review procedures, which required Connecticut General to notify the Kannes of their rights to review of its decision denying this claim. See, e.g., 29 CFR Section 2560.503-1(f)(g).

Thus, while Connecticut General has insisted throughout this litigation that this matter is governed by ERISA, it ignored ERISA requirements when compliance with these requirements was inconvenient or potentially costly to it, and none of the entities involved in this case (i.e., Connecticut General, Harlow Carpets or ABC Trust) has ever shown that they complied with any of ERISA's requirements.

Section 790.03(h)(2), which prohibits the failure to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies (Appendix A, pp. 32-33). He found that Connecticut General's behavior caused the Kannes emotional distress damages in the sum of $250,000 (Appendix A, pp. 37-38), and that Connecticut General's behavior was so outrageous that an award of $500,000 exemplary damages was appropriate as a penalty and deterrent (Appenix A, pp. 37-38).

The District Court also held that the insurance covered the air ambulance expenses (Appendix A, pp. 16-20). Another insurer, Metropolitan Life Ins. Co., had paid its share of these expenses (id, p.7), leaving a balance of $2,234.88 that was payable by Connecticut General (id at p.20).

The District Court also considered Connecticut General's contention that ERISA preempted the Kannes' cause of action and stated that the insurance arrangement was an ERISA plan (Appendix A at p.12). The District Court did not state its reasons for this conclusion, which was immaterial to the decision, since the District Court also concluded that ERISA did not preempt the Kannes' causes of action (id at pp. 12-14). [9]

Respondent appealed the District Court's judgment to the Ninth Circuit

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9. At about the time of the District Court's decision, there were a number of cases holding that ERISA preemption did not apply to actions for insurance bad faith, because of the saving clause, 29 U.S.C. Section 1144(b)(2)(A). See, e.g.: Presti v. Connecticut General Life Ins. Co., 605 F.Supp. 163 (N.D. Cal. 1985); McLaughlin v. Connecticut General Life Ins. Co., 565 F.Supp. 434 (N.D. Cal. 1983); Eversole v. Metropolitan Life Ins. Co., 500 F.Supp. 1162 (C.D. Cal. 1980).

Court of Appeals. The appeal was first argued and submitted on April 7, 1986 (Appendix D at p.75). On July 2, 1986, the appeal was withdrawn from submission, pending this Court's decision in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549 (1987) (Appendix D at pp. 76, 82). On June 4, 1987, after Pilot Life was decided, the Court of Appeals resubmitted the case and reversed the District Court's conclusion that the Kannes' claims were not preempted (Appendix B, pp. 44-52, Appendix D, pp. 83-84). On July 23, 1987, the Court of Appeals granted the Kannes' petition for rehearing and directed the parties to brief two issues: whether the Kannes' cause of action under California Insurance Code Section 790.03(h)(2) is preempted by ERISA and whether the insurance policy in question is a plan

governed by ERISA. 823 F.2d 284, Appendix D, pp. 77 and 84. On November 23, 1987, the Court of Appeals heard oral argument on these issues (Appendix D at p.76).

On October 4, 1988, the Court of Appeals filed its opinion, reversing the District Court's decision (Appendix C, pp. 53-74). The Kannes filed another petition for rehearing on October 18, 1988. On February 2, 1989, the Court of Appeals modified its opinion and denied the petition for rehearing (Appendix D, at pp. 75, et seq.).

As the opinion of the Court of Appeals demonstrates, the disposition of the issue of whether ERISA preempts petitioners' State law remedies under the State statute, California Insurance Code Section 790.03(h), depends on the interpretation of this Court's decision

in Pilot Life Ins. Co. v. Dedeaux, supra (see Appendix D at pp. 91-96). The Kannes contended that Pilot Life was inapplicable because that case held only that ERISA preempted common law causes of action which were not state laws regulating insurance, and hence did not come within the ERISA savings clause. The Kannes contended that their cause of action for breach of California Insurance Code Section 790.03(h)(2) is exempt from ERISA by the savings clause, since Section 790.03(h)(2) is a law which regulates insurance (Appendix D at p.93).

The Court of Appeals held that it was unnecessary to determine that issue. The Court said:

> "We can assume, without deciding, that section 790.03(h) is a law regulating insurance under the savings clause." (Appendix D at p. 93) (emphasis added)

The Court of Appeals held that ERISA preempted petitioners' cause of action even if that cause of action was based on a State law regulating insurance within the meaning of the savings clause (Appendix D at pp. 93-96). The Court of Appeals interpreted the second part of this Court's decision in Pilot Life (481 U.S. at pp. 51-57, 107 S.Ct. at pp. 1555-8) to mean that ERISA civil enforcement provisions are exclusive even where plaintiffs are proceeding under a State law regulating insurance (Appendix D at pp. 93-96).

The Court of Appeals also held that the insurance arrangement was a plan subject to ERISA (Appendix D at pp. 84-91). The Court recognized that under Department of Labor regulation 29 CFR Section 2510.3-1(j) (1987) a group insurance program is excluded from ERISA

if it contains the four criteria described therein (Appendix D, pp. 87-88). The Court concluded that the evidence failed to establish that Mr. Kanne's actual employer, Harlow Carpets, had conducted any activities which would take the insurance arrangement outside the four criteria of the regulation (Appendix D at pp. 88-89). However, the Court held that Associated Builders & Contractors (ABC), which purchased the group insurance from Connecticut General, could be considered an "ERISA employer," under 29 U.S.C. Section 1002(5) (Appendix D at pp. 89-90), which provides that an "employer" includes "a group or association of employers acting for an employer in such capacity." [10]

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10. As the Court knows, in order for a plan to be governed by ERISA, it must be established or maintained by any

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The Court of Appeals held that ABC was an employer group or association within the meaning of 29 U.S.C. Section 1002(5), and that the arrangement was an ERISA plan because "ABC does not merely advertise the group insurance, but rather, as the administrator of the plan, 'endorses' it," thereby establishing the non-existence of one of the four criteria set forth in 29 CFR Section 2510.3-1(j) for excluding a plan from ERISA (the third criterion) (Appendix D at p.90). The Court concluded that if any of the four criteria are absent, an ERISA plan is established. See Appendix D at pp. 88, 89.

However, the opinion acknowledges

"employer" (unless it is established or maintained by an employee organization, which is not claimed here). 29 U.S.C. Section 1003(a), set forth in Appendix E, infra.

that at the trial "the parties did not contest the issue of whether the ABC Trust was an ERISA plan" (Appendix D, p.86), and this issue was never litigated. Hence, the opinion's assumption that ABC was a bona fide employer group within the meaning of 29 U.S.C. Section 1002(5) is not supported by any evidence. See Section EII, infra. [11]

Finally, the Court held that even the Kannes' claim for reimbursement of the air ambulance costs was preempted (Appendix D, pp. 96-97). The Court said that California's common law of contracts is not a law that regulates insurance (id

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11. These matters were pointed out in petitioners' petition for rehearing to the Court of Appeals filed October 18, 1988.

The Court of Appeals' modification of the opinion on denial of the rehearing (Appendix D) did not further discuss these matters.

at p. 97). The Court did not discuss any reason that this claim could not be recovered under ERISA (see 29 U.S.C. Section 1132[a][1][B]). The Court of Appeals apparently assumed that the "arbitrary and capricious" standard governed claims brought under ERISA, as contended by Connecticut General (see, e.g., Connecticut General's reply brief filed in the Court of Appeals, served January 30, 1986, at p. 36).

E. REASONS THE WRIT SHOULD BE GRANTED

I. THE ISSUE OF WHETHER ERISA PREEMPTS STATE LAW REMEDIES PROVIDED BY A STATE LAW REGULATING INSURANCE IS AN ISSUE OF WIDESPREAD IMPORTANCE; IT IS URGENT THAT THIS COURT RESOLVE THIS ISSUE. [12]

The first question presented clearly comes within the criteria of Rule 17.1. It is of tremendous importance and impacts on the rights of literally millions of citizens of this country who have employee group health and medical insurance policies and seek State law

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12. As noted above (Footnote 1, supra), the identical issue is presented in the Petition for Writ of Certiorari in the Commercial Life case, supra. We have read that petition and adopt the arguments contained therein by reference. We will hereinbelow address ourselves to additional reasons that the instant issue merits the granting of the Kannes' petition.

remedies when the insurers' failure to honor these policies causes serious hardship to ill and disabled policyholders.

Indeed, the importance of this issue has been conceded by one of respondent's counsel, David L. Bacon, Esq., who has said that "[i]t's hard to overstate the importance" of the Court of Appeals' decision in the instant case (Los Angeles Daily Journal, October 5, 1988, p.1., column 4) and "[t]here are hundreds of pending suits in California which involve this very issue and hundreds and [sic] millions of dollars [are] involved." (Wall Street Journal, October 5, 1988, p.A-24, column 4).

In California alone, there are scores, if not hundreds, of cases pending whose resolution is determined by the issue of whether a citizen of a State may

seek State law remedies for redress of violations of State laws regulating insurance. In Commercial Life Ins. Co. v. Superior Court, supra, the California Supreme Court, in holding that actions for breach of State laws regulating insurance are preempted by ERISA, relied extensively on the decision of the Court of Appeals in the present Kanne case. See 47 Cal. 3d at pp. 482-484, 764 P.2d at pp. 1064-1066. [13] There are

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13. The California Supreme Court took for review at least five other cases presenting the same issue: Goodrich v. Gen. Tel. Co., supra, No. S002951, DeFiori v. Bankers Life, No. S003448, Pilot Life v. Superior Court, No. S003351, Blue Cross of Cal. v. Superior Court, No. S004471 and General Tire & Rubber Co. v. Superior Court, No. LA32272. It retransferred these cases to the California Courts of Appeal on February 23, 1989 for reconsideration in the light of the Commercial Life decision. Commercial Life and these five other cases which had already reached the California Supreme Court are just the tip of the iceberg.

countless other cases pending in the Ninth Circuit and U.S. District Courts of California and in the California State Courts which present the very same issue. [14]

Although the California Supreme Court has now judicially abolished the private right of action under California Insurance Code Section 790.03(h), the Court made it clear that the Legislature of the State of California has the power to reinstate this right of action.

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14. The instant Kanne case is the leading federal case on the subject, and its importance is underscored by the numerous Amicus Curiae Briefs filed in the Court of Appeals. Amicus Curiae included the United States Government in support of Connecticut General and the Attorney General of the State of California in support of the Kannes. The American Council of Life Insurance, the Health Insurance Association of America and the Association of California Life Insurance Companies also filed Amicus Curiae Briefs in support of Connecticut General. Other "numerous amici" supported the Kannes (Appendix D at pp. 78, 93).

Moradi-Shalal v. Fireman's Fund Ins. Cos., 46 Cal.3d 287, 305, 758 P.2d 58, 69 (1988). Moreover, the Moradi-Shalal decision applies prospectively only, and does not affect the large number of pending cases asserting causes of action under California Insurance Code Section 790.03(h). See 46 Cal.3d at p.305, 758 P.2d at p. 69.

Nor is the reach of the present issue confined to California. Numerous other states have laws which seek to deter unfair insurance practices by assessing various penalties. See, e.g.: Van Dyke v. St. Paul Fire & Marine Ins. Co., 448 N.E.2d 357 (Mass. 1983) (cause of action allowed for breach of Massachusetts' Insurance Unfair Claims Practices Act); Griswold v. Union Labor Life Ins. Co., 442 At1.2d 920 (Conn. 1982) and Mead v. Burns, 509 At1.2d 11

(Conn. 1986) (cause of action allowed for breach of Connecticut's Unfair Trade Practices Act); Sparks v. Republic Nat. Life Ins. Co., 647 P.2d 1127 (Ariz. 1982), cert. den., 459 U.S. 1070, 103 S.Ct. 490 (1982) (to the same effect under Ariz. Rev. Stats Section 20-443); Jenkins v. J.C. Penney Cas. Ins. Co., 280 S.E. 2d 252 (W.Va. 1981) (to the same effect under West Virginia statute); Klaudt v. Flink, 658 P.2d 1065 (Mont. 1983) (to the same effect under Montana statute); Mo. Rev. Stat. Section 375.296 (allowing extracontractual damages and attorneys fees against insurance companies for vexatious refusal to pay); Tex. Ins. Code Ann. Art. 3.62 (same); La. Rev. Stats 22:657 (providing for penalties for failure to promptly pay claims arising out of health and accident contracts).

The foregoing statutes, and similar statutes in other states, will be rendered a nullity under the Kanne Court's interpretation of this Court's decision in Pilot Life, supra. The Kanne Court's interpretation of Pilot Life in effect attributes to this Court's opinion in Pilot Life a statutory interpretation which ignores the plain words of the statute. The Kanne Court's interpretation is that the savings clause does not apply to ERISA's enforcement provisions. This is plainly incorrect.

The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance..." 29 U.S.C. Section 1144(b)(2)(A) (emphasis added). The "subchapter" referred to is Subchapter I of ERISA, entitled "Protection of

Employee Benefit Rights." The savings clause is in Part 5 of Subchapter I. The ERISA enforcement provisions are also in Part 5 of Subchapter I. See 29 U.S.C. Section 1132. Hence, the statute clearly provides that ERISA's enforcement provisions do not apply to State laws regulating insurance. To interpret Pilot Life as holding otherwise would impute to this Court an intention to ignore the plain words of the statute--an intention which cannot be imputed to this Court.

It is particularly inappropriate to impute such an intention to this Court from statements in the Pilot Life decision because the issue was not before this Court in Pilot Life. Pilot Life did not involve a State law regulating

insurance. [15]

We believe that the more rational interpretation of the second half of Pilot Life--and the interpretation consistent with the statutory language--is that the discussion therein merely was

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15. Two other Court of Appeals decisions have interpreted Pilot Life in a fashion similar to the Ninth Circuit's interpretation. See, e.g.: In Re: Life Ins. Co. of North America, 857 F.2d 1190 (8th Cir. 1988) (the Court held that ERISA preempts Mo. Rev. Stat. Section 375.420, which provides a penalty for vexatious refusal to pay insurance benefits. The Court relied on the second portion of the Pilot Life opinion, which it construed as holding that "no state law purporting to supply additional remedies will escape the preemptive effect of Section 1144(a) as laws 'which regulate insurance' under Section 1144(b)(2)(A)" [857 Fed. 2d at p.1194]); Anschultz v. Connecticut General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) (holding that under Pilot Life, ERISA preempts the Florida Insurance Unfair Practices Act, Florida Stat. Section 624.155. The Court, relying on the second portion of Pilot Life, held: "where otherwise applicable, ERISA preempts all state law." [850 F.2d at p.1469] [emphasis in original]).

intended to set out another element to consider in determining whether a State law regulates insurance so as to come within the saving clause. In discussing the criteria to be utilized in determining whether the saving clause applies, this Court in Pilot Life said that several considerations guided it. 481 U.S. at p.48, 107 S.Ct. at p. 1553. First, this Court was guided by a "common-sense view of the language of the saving clause itself" (ibid). Then, it applied the three criteria set forth in Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009 (1982) (481 U.S. at pp. 48-51, 107 S.Ct. at pp. 1553-4). Finally, in the portion of Pilot Life relied on by the Court of Appeals in the instant case, this Court considered the role of ERISA in promoting uniformity of enforcement for actions by

ERISA-plan participants and beneficiaries (481 U.S. at pp. 51-57, 107 S.Ct. at pp. 1555-1558).

We submit that this last criterion constitutes a criterion this Court considered in determining the scope of the saving clause and it alone cannot take a state law regulating insurance outside the ambit of the saving clause. Otherwise, it would nullify the saving clause completely, and would make superfluous this Court's previous discussion in the Pilot Life opinion as to whether the State law in question regulated insurance and satisfied the Union Labor Life requirements.

Thus, the opinion in Pilot Life concludes with the statement that the "state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by

Section 514(b)(2)(a) and therefore is pre-empted by Section 514(a)." (481 U.S. at p. 57, 107 S.Ct. at p.1558) (emphasis added). We interpret this to mean that the suit was pre-empted because the law involved was not a State law regulating insurance within the saving clause. It does not mean that suits based on State laws which do regulate insurance and are hence within the saving clause are also subject to pre-emption. If this Court intended to hold that ERISA's enforcement provisions preempt all State laws regardless of whether or not they regulate insurance, it would have been wholly unnecessary for this Court to extensively discuss all of the reasons that the Mississippi common law rules involved in Pilot Life did not constitute a state law regulating insurance.

This conclusion is supported by this

Court's decision in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380 (1985), where this Court held that there is a presumption against pre-emption of areas of "traditional state regulation" (471 U.S. at p.740, 105 S.Ct. at p.2389) and that "we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope." (471 U.S. at p.741, 105 S.Ct. at p.2390). This Court rejected the contention that "Congress intended [a] narrow reading of the saving clause." (471 U.S. at pp. 745-746, 105 S.Ct. at p. 2392. See also 471 U.S. at pp. 746-747, 105 S.Ct. at p.2393). This Court stated that the saving clause is "broad on its face" (471 U.S. at p. 746, FN 24, 105 S.Ct. at p.2393, FN 24). These statements establish that the saving clause may not be nullified by refusing

to apply it to a situation that comes squarely within its terms.

The interpretation of the Court of Appeals in the instant case would mean that this Court did a complete about face only two years after Metropolitan Life was decided. Pilot Life contains nothing to indicate that this Court intended to effect such a sweeping reversal of the holding in Metropolitan Life.

We respectfully submit that the District Court in Graves v. Blue Cross of California, 688 F.Supp. 1405 (N.D. Cal. 1988) correctly interpreted Pilot Life. Therein, the Court rejected the interpretation that the second half of Pilot Life limited actions under State laws regulating insurance to ERISA remedies. The Court said:

> "...such a holding would conflict with both the language of ERISA itself and the Supreme

Court's pronouncements in Metropolitan Life. . .Since ERISA's civil enforcement provisions are contained in the same subchapter as the saving clause, see 29 U.S.C. Section 1132, the plain language of the statute precludes a ruling that state laws falling within the boundaries of the saving clause are nevertheless preempted if they interfere with the policies underlying the exclusive civil enforcement scheme. In effect, such a holding would rewrite the saving clause..." (688 F.Supp. at pp. 1412-1413) (emphasis added).

The District Court then noted the language of Metropolitan Ins. Co. v. Massachusetts, supra, and said:

"In this Court's view, the only way to square Pilot Life with Metropolitan Life and the plain language of ERISA is to read the Pilot Life exclusivity analysis as merely bolstering the Court's apparent conclusion that the Mississippi bad faith law was not insurance regulation within the meaning of the saving clause. In other words, the insurance regulation and exclusive remedy discussion in Pilot Life are not independent, alternative

> holdings, but interdependent considerations supporting the Court's conclusion that the saving clause does not apply." (688 F.Supp. at p.1413) (emphasis added)

In Commercial Life, supra, the dissenting opinion of Justice Mosk (joined in by Justice Broussard) points out that under the statute it is plain "that Section 790.03(h) is saved from preemption by the express terms of ERISA: the provision clearly 'regulates insurance' [citation]. As I read their opinion, the majority do not seriously dispute that section 790.03(h) comes within ERISA's saving clause--nor could they [citation]. * * * ERISA does not preempt Section 790.03(h), but expressly saves the provision as a law 'regulat[ing] insurance.' Further, the civil enforcement scheme of the federal statute does not displace the civil

enforcement scheme of the state act: the former concerns the rights of employees under covered plans, the latter the duties of insurers under state laws." (47 Cal. 3d at pp. 488-489, 764 P.2d at pp. 1068-1069).

Justice Mosk then said:

> "There is a growing and ominous trend toward federal preemption of issues that belong within the sphere of control by the individual states. And these inroads into traditional federalism are taking place despite their inconsistency with pious rhetoric emanating from Washington about returning government to the people at state and local levels." (47 Cal. 3d at p. 490, 764 P.2d at p.1069) (emphasis added).

We respectfully submit that these comments are particularly appropriate in light of the fact that the insurance industry--with all the vast and able legal resources at its command--has been unable to cite in support of its position

one single expression from Congress in all of the writings on ERISA's legislative history. Nothing in that history shows that Congress intended to place sick and disabled beneficiaries of employee group insurance plans at the mercy of their insurers. To the contrary, the saving clause constitutes a plain expression of Congress' intent to leave to the States the traditional State law regulation of the duties of insurers to the States' citizens, as Justice Mosk pointed out. See also: Petition for Writ of Certiorari in Commercial Life, supra, which sets forth other authorities regarding the intent of Congress.

We respectfully submit that these serious questions concerning interpretation of Pilot Life urgently require this Court to grant the instant petition and definitively resolve the

question of whether or not the States are powerless to enact or enforce legislation designed to deter insurance companies from inflicting on a State's citizens anguish and hardship such as that suffered by the Kannes at bar. We respectfully submit that this issue is a vitally important question of federal law which has not been, but should be, settled by this Court (Rule 17.1(c)), regardless of whether we are right or wrong with respect to the ultimate result.

II. THE ISSUE OF THE ELEMENTS NECESSARY TO ESTABLISH THAT AN INSURANCE ARRANGEMENT IS AN "EMPLOYEE BENEFIT PLAN" SUBJECT TO ERISA IS AN ISSUE OF WIDE-SPREAD IMPORTANCE WHICH HAS NEVER BEEN RULED ON BY THIS COURT.

The issue of the elements necessary to establish that a group insurance policy is an "employee benefit plan" subject to ERISA, pursuant to 29 U.S.C. Section 1003(a), is also appropriate for review, under the criteria of both Rule 17.1(a) and (c). As will be seen below, the instant decision is in conflict with other Court of Appeals decisions on this issue. It is a vital issue which affects every insurance arrangement made in an employment setting. It affects the rights of citizens of States to pursue State law remedies in cases where an employer arranges for an insurance policy covering its employees, but there is no written employee benefit plan and no evidence that the employer had any intention whatever to establish an employee benefit plan subject to ERISA or made any attempt to comply with the

various ERISA regulations governing such plans. Such regulations include numerous onerous reporting and record keeping requirements. See, e.g. 29 U.S.C. Sections 1021-1029. An employer who willfully violates any of these provisions is guilty of a criminal act, subjecting that employer to fine and imprisonment. 29 U.S.C. Section 1131. See Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208, 1211 (5th Cir. 1980), cert. den. sub. nom., Taggart Corp. v. Efros, 450 U.S. 1030, 101 S.Ct. 1739 (1981).

We respectfully submit that employers, who are subject to criminal prosecution, and employees, who are threatened with loss of valuable rights under State law, should be clearly and definitively advised by this Court of the circumstances when an insurance

arrangement constitutes an "employee benefit plan" subject to ERISA.

This Court has never spoken on this issue. A leading case from this Court makes it clear that the provisions of ERISA do not apply unless there is a plan or program. Fort Halifax Packing Co. v. Coyne, ____ U.S. ____, 107 S.Ct. 2211 (1987). It does not address the issue of the elements necessary to establish such a plan or program.

The present opinion of the Court of Appeals graphically demonstrates the confusion and conflict among the Courts on this issue. The Court of Appeals' finding that an unwritten "employee benefit plan" subject to ERISA existed in the present case was based on at least two propositions that are the subject of conflict among the authorities:

(1) The proposition that the

nonexistence or absence of any of the four criteria set forth in Department of Labor regulation 29 CFR Section 2510.3-1(j) is sufficient to subject an insurance arrangement to ERISA (see Section D, supra, Appendix D at pp. 88, 89, 90).

(2) The proposition that the acts of an employer association, as defined in 29 U.S.C. Section 1002(5), is sufficient to subject an insurance arrangement to ERISA, even when there is no evidence that the direct employer played any part in the management of the employer association and no evidence that the employer association consisted of homogeneous, related employers (Section D, supra. Appendix D at pp. 86, 89-90).

In the present case, the Court of Appeals relied on these two propositions to strip the Kannes of their rights under

well-established State law--and of the fruits of this protracted and expensive litigation.

The questionable nature of the first proposition is established by holdings that the nonexistence of one of the four criteria set forth in the Department of Labor regulation does not establish that an insurance arrangement is subect to ERISA. Thus, for example, in Rizzi v. Blue Cross of So. Cal, 206 Cal. App. 3d 380, 253 Cal. Rptr. 541 (1988) the Court analyzed the authorities and pointed out that some authorities have held that there is no ERISA plan "where the employer 'endorsed' the policy sold by an insurance trust, but the employer had no control of the trust operation, contributed no funds on behalf of the employees, and the insurance brokers sold the policies directly to individual

employees who paid the entire premiums. [citations]" 206 Cal. App. 3d at p.386, 253 Cal. Rptr. at p.545 (emphasis added). At bar, on the other hand, the alleged presence of endorsement, which established the non-existence of the third criterion in the Department of Labor regulation, was held to be sufficient by itself to establish an unwritten ERISA plan. See Appendix D at pp. 88, 89, 90. See also: Sayble v. Blue Cross of So. Cal., ___ Cal. App. 3d ___, ___ Cal. Rptr. ___, filed March 20, 1989 (reported in the Los Angeles Daily Journal Daily Appellate Reports for March 22, 1989 at p. 3587) (the Court held that payment of premiums, which established the non-existence of the first criterion in the Department of Labor regulation, was not sufficient to establish an employee benefit plan where, as at bar,

there was no evidence of any other employer involvement).

Moreover, in the present case the Court of Appeals did not even find that Mr. Kanne's direct employer's involvement established the absence of any of the four Department of Labor criteria. The Court of Appeals found only that the acts of ABC, an alleged employer group, constituted "endorsement," establishing the absence of the third criterion (Appendix D, pp. 88-90).

However, in order to be an "ERISA employer" under 29 U.S.C. Section 1002(5), an alleged employer group or association must be "a group or association of employers acting for an employer in such capacity." It has been held that an employer association is not an "ERISA employer" under this provision, unless the evidence establishes that the

individual employer played a part in management of the employer association. If the employer association fails to show what role the individual employers played in its management, it is not covered by ERISA. See, e.g., Matthew 25 Ministries, Inc., v. Corcoran, 771 F.2d 21 (2d Cir. 1985); Donovan v. Dillingham, 688 F.2d 1367, 1373, FN 11 (11th Cir. 1982). See also Hamberlin v. VIP Ins. Trust, 434 F.Supp. 1196, 1198 (D. Ariz. 1977) (for an employer group to be an ERISA plan, the employers must have a voice in its management); Baucom v. Pilot Life Ins. Co., 674 F.Supp. 1175, 1181 (M.D.N.C. 1987) (same); Insurance & Prepaid Benefits Trusts v. Marshall, 90 FRD 703 (C.D. Cal. 1981) (an employer group can qualify as an ERISA plan only when such group involves an association of employers, the employers participate in

the benefit committee and that committee makes final decisions). See also: Rizzi, supra.

Moreover, where an employer group consists of "heterogeneous, unrelated employers," ERISA is inapplicable. Credit Managers Ass'n v. Kennesaw Life & Acc. Ins., 809 F.2d 617, 625 (9th Cir. 1987). In the Rizzi case, supra, the California Court of Appeal specifically questioned the instant Kanne decision because of this rule (206 Cal. App. 3d at p.386, FN 4, 253 Cal. Rptr. at p.544, FN 4).

Thus, the Court of Appeals' holding in the instant case is directly contrary to all of the above authorities, since there was no evidence that Harlow Carpets (or, for that matter, any other employer) played any part in the management of ABC, the purported "ERISA employer," and no

evidence that ABC was a group of homogeneous, related employers.

Another conflict among the authorities is presented by the question of whether employer intent is necessary to establish an unwritten employee benefit plan subject to ERISA.

In Wayne Chemical v. Columbus Agency Service Corp., 567 F.2d 692 (7th Cir. 1977), the Court held that an employee benefit plan governed by ERISA is not established when the employer applies for insurance and pays premiums "without any knowledge that the plan exists. Establishing, maintaining or participating in a plan requires an intent, ..." (567 F.2d at p.699) (emphasis added) Similarly, the opinion of the Court of Appeals in the present case also indicates that an intent to form an ERISA plan is necessary, since it

found such intent, although only on the part of ABC (Appendix D at p.90). On the other hand, Donovan v. Dillingham, supra, indicates that intent is unnecessary, since it sets forth different criteria for determining whether a plan is governed by ERISA (688 F.2d at p. 1373). [16] Rizzi, supra, specifically raises the question of "whether a test based on an employer's subjective intent is appropriate." (206 Cal. App. 3d at p. 387, FN 7, 253 Cal. Rptr. at p.545, FN 7).

The Courts of Appeal are also in conflict on the subject of whether the "bare purchases of health insurance" may constitute a "plan" subject to ERISA.

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16. The Donovan test is "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits" (688 F.2d at p. 1373).

Taggart Corp. v. Life & Health Benefits Admin., supra, 617 F.2d 1208, 1211, held that there is no ERISA plan under these circumstances. Donovan v. Dillingham, supra, holds that "bare purchases of health insurance" is evidence of an employee benefit plan governed by ERISA and the issue is one of fact to be decided on a case by case basis (688 F.2d at p.1373). Donovan specifically disapproves the holding of Taggart Corp., supra, on this subject. (688 F.2d at p. 1375).

In Rizzi v. Blue Cross of So. Cal., supra, the California Court of Appeal noted the confusion and inconsistency among the authorities (206 Cal. App. 3d at pp. 384-388, 253 Cal. Rptr. at pp. 543-546), stating that the various "analytical approaches" the Courts have considered "do not always coincide" (206

Cal.App.3d at p. 389, 253 Cal.Rptr. at p. 547).

Indeed, as noted above (FN 2, supra), counsel for respondent have themselves advised this Court that there is "An Increasingly Significant Circuit Split And Wide-Spread Division And Error In The Lower Courts" on this subject (Petition in Pacific Mutual Life Ins Co. v. Turnbow, supra, p. 16); a "sharp Circuit conflict" on this subject (id. at p. 18); and "increasing division and error in the lower courts on ERISA's most basic issues of coverage and preemption, all stemming from an irreconcilable Circuit conflict." (id. at p. 19).

It is therefore clear that the certainty so urgently needed on this subject is utterly lacking, and it is vital that this Court issue a definitive pronouncement of the criteria that

determine what constitutes an employee benefit plan governed by ERISA, under 29 U.S.C. Section 1003(a). We respectfully suggest that this Court should adopt criteria which may be easily understood and applied.

We respectfully submit that it would be error to permit vague, ambiguous and obscure criteria to determine this question, and particularly because of the criminal sanctions which may be imposed upon employers for failure to comply with ERISA requirements, under 29 U.S.C. Section 1131. It is elementary that a criminal statute must be plain and unambiguous. Under current authorities, there is no way of knowing with certainty when ERISA is applicable and when the duty of compliance with ERISA regulations arises.

We therefore respectfully submit

that it is urgently necessary that the state and federal courts throughout this country receive concrete guidance from this Court on this subject. Otherwise, confusion and uncertainty will proliferate and will create intolerable chaos in the state and federal court systems. [17]

Conclusion

This Court's decision in Pilot Life, supra, urgently requires clarification in order that the States may know whether or

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17. Prior to this Court's decision in Pilot Life, most courts had held that ERISA did not preempt common law causes of action for bad faith. See, e.g., cases cited at FN 9, supra. Under Pilot Life there are a large number of common law bad faith cases throughout the country that would be preempted by ERISA, if it applies, and the issue of whether it applies, which was largely academic before Pilot Life, has now become pivotal. See, e.g., Appendix D at pp. 86-87.

not they have the power to enact laws regulating insurance which will effectively deter predatory insurance practices such as those demonstrated by the record at bar. It was never the intention of Congress to handcuff the States' ability to protect their citizens from the hardships which may result from such practices. Nor did Congress intend to compel health care providers, such as hospitals--whose costs and finances are already a grave national problem--to, in effect, make interest-free loans to insurance companies (see FN 6, supra).

It is also urgently necessary that the State and Federal Courts be afforded guidance with respect to when the federal law embodied in ERISA applies to medical and disability insurance arrangements that are not the subject of any written employee benefit plan. The consequences

of the present state of confusion and uncertainty are most grave. All sides to this controversy agree that an authoritative pronouncement from this Court is necessary to prevent the further spread of this deeply troubling confusion and uncertainty.

Respectfully submitted,

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88-1659

Supreme Court, U.S.
FILED
APR 11 1989

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

APPENDIX TO
PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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Vol. II of II

APPENDIX A

APPENDIX A

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

THEODORE KANNE, and BEATRIZ KANNE, Plaintiffs, v CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a Connecticut corporation; THE LINCOLN NATIONAL LIFE INSURANCE COMPANY, an Indiana corporation; METROPOLITAN LIFE INSURANCE COMPANY, a New York corporation; HARLOW CARPETS INC. a California corporation; HART, SHAFFNER & MARX, a General Partnership; DOES 1 through 50, Inclusive, Defendants.	NO. CV 83-2261-ER AMENDED MEMORANDUM DECISION

This matter came on regularly for trial on March 6, 1984, before the Honorable Edward Rafeedie, United States District Judge. Plaintiffs Theodore Kanne and Beatriz Kanne appeared with their attorneys of record, Carol A. Hay and Ernest

Franceschi, Jr. Defendant Connecticut General Life Insurance Company appeared through its attorneys of record, Adams, Duque & Hazeltine, by James Cline and Suzette Clover. The Court, heard the testimony of witnesses, having received oral and documentary evidence in the matter and having considered the pleadings and all of the records and files herein, renders its decision as follows:

I. BACKGROUND

1. Procedural

On December 17, 1982 plaintiffs Theodore Kanne ("Theodore") and Beatriz Kanne ("Beatriz") filed this civil action in the Superior Court of the State of California for the County of Los Angeles. The defendants at that time were Connecticut General Life Insurance Company ("Connecticut General"), Lincoln National Life, Metropolitan Life Insurance Company ("Metropolitan"),

Harlow Carpets, Inc. ("Harlow Carpets") and Hart, Shaffner & Marx. The complaint sought compensatory and punitive damages under state law for (1) breach of contract by failing to pay claims for medical benefits within a reasonable period of time, (2) breach of the implied covenant of good faith and fair dealing, (3) breach of fiduciary duties, (4) common law fraud, and (5) breach of statutory duties under California Insurance Code § 790.03.

Connecticut General and Metropolitan answered the complaint on March 18, 1983. In their answer, they denied plaintiffs' allegations and raised affirmative defenses, including failure to state a claim for relief as to all causes of action, full payment of benefits due, privilege to assert one's rights in good faith, the bars of California Insurance Code § 10111 and Civil Code § 3302, failure to mitigate

damages, preemption by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001-1381, ("ERISA"), failure to exhaust administrative remedies under ERISA, and the unconstitutionality of allowing punitive damages against the defendant for breach of the covenant of good faith and fair dealing.

On February 4, 1983, plaintiffs filed a Motion to Remand. The Court granted the motion on March 24, 1983. After the parties stipulated to the dismissal of Lincoln National Life Insurance Company and Harlow Carpets on March 3, 1983, the action again was removed to federal court on April 8, 1983 on the basis of diversity jurisdiction. On April 19, 1983, Hart, Shaffner & Marx filed a Motion to Dismiss Extra-Contractual Claims, which the Court granted on May 23, 1983. On April 13, 1983, Metropolitan filed a Motion for Summary Judgment, which the Court granted on June 17, 1983. Although

plaintiffs appealed these determinations, they subsequently dismissed their appeals. Finally, upon reaching a settlement with Hart, Shaffner & Marx on November 1, 1983, plaintiffs requested that Hart, Shaffner & Marx be dismissed with prejudice. The Court granted this request.

2. Factual

On May 23, 1981, Theodore was an employee of Harlow Carpets. Since Connecticut General had issued a group medical insurance policy (the "policy") to the ABC Trust, of which Harlow Carpets was a member, Theodore was covered as an eligible employee under the policy. The ABC Trust is administered by the Associated Builders and Contractors in Washington, D.C. Similarly, on the same date, Beatriz was covered as an eligible employee under a self-funded ERISA plan at her place of employment, Hart, Shaffner & Marx. This plan was

administered by Metropolitan Life Insurance Company.[1/]

Jonathan Kanne ("Jonathan") was born on May 23, 1981 to Theodore and Beatriz while they were vacationing in Holland. Although the policy provided primary coverage for Jonathan only from the date of application by his parents, ABC Trust later authorized coverage retroactive to May 23, 1981. The Hart, Shaffner & Marx policy provided Jonathan with secondary coverage from May 23, 1981 through January 31, 1982.

Jonathan was born two months early with congestive heart failure. Within two weeks he was diagnosed as being cyanotic (a "blue baby") as a result of the heart failure. Shortly thereafter, Theodore provided this information to Connecticut General.

Doctors in Holland subsequently recommended that Jonathan be treated at Moffitt Hospital in San Francisco. Theodore advised

Metropolitan of this recommendation and requested an advance payment for air transportation fees on KLM, Royal Dutch Airlines, in the sum of $3,000.00 This amount was to cover first class airfare for Beatriz and Jonathan, oxygen for Jonathan while in first class, and modification of the plane's electrical system necessitated by Jonathan's need for oxygen.

Because Connecticut General and Metropolitan refused to advance any portion of the requested sums, Theodore drove to Mexico to borrow the necessary money from his father. Jonathan thereafter was transported from Amsterdam to Los Angeles by KLM Airlines and from Los Angeles to San Francisco by Schaffer Air Ambulance.

After Jonathan arrived in San Francisco, Theodore obtained reimbursement in the sum of $698.40 from Metropolitan. Theodore then sought to recover the balance from

Connecticut General under a coordination of benefits arrangement between the two insurance companies.

The Kannes dealt with Rosa Monostroi ("Rosa"), the Connecticut General Senior Benefits Analyst with primary responsibility for handling claims of the ABC Trust involving employees and dependents of Harlow Carpets. Rosa initially rejected the KLM claim on the ground that San Francisco was not the nearest hospital to Amsterdam. Thereafter, she changed her reasoning, determining instead that the treatment Jonathan was to receive in San Francisco was neither essential nor medically necessary.[2/] She based these decisions on the wording of the policy which covers: "Charges for professional ambulance services to or from the nearest hospital where necessary care and treatment can be given." Rosa, however, determined that the Schaffer

Air Ambulance bill was covered by the policy and, therefore, paid this claim promptly.

On October 22, 1982, Los Angeles Children's Hospital mailed to Connecticut General medical bills incurred by Jonathan for emergency surgery on September 15, 1981. Similarly, other medical providers involved in this hospital stay presented their medical bills to Connecticut General within a reasonable time after they were incurred. Notwithstanding provisions in the policy booklet calling for immediate payment upon receipt of proof of loss, Connecticut General delayed payment of a majority of these medical bills for three to eleven months after presentation. Similarly, Connecticut General delayed payment for over eight months of the claims sustained by Jonathan's hospitalization at Los Angeles Children's Hospital beginning on October 16, 1981. Theodore repeatedly telephoned Rosa

who explained to him that the reason the bills had not been paid was that they had not been received. The claims file documents kept by Connecticut General, however, show that an itemized bill from Children's Hospital in the total amount of $89,840.16 was received by Connecticut General on December 29, 1981. Connecticut General paid $9,999.00 of that claim in February 1982, and $9,999.00 on March 1982. The latter part of October it paid $69,141.44 after it had received a collection agency claim in September 1982. It made a last payment of $776.00 in late October 1982, after plaintiffs had retained counsel.

Connecticut General provided no explanation or justification for the delay in the payment of the $69,141.44 incurred by Children's Hospital from October 16, 1981 to November 13, 1981. Although Rosa testified that she did not receive an

itemized bill for the $69,141.44, Connecticut General, as stated above, admits receiving the Children's Hospital bill in the sum of $89,840.16 on December 29, 1981. The balance forward on that bill was $69,141.44. Rosa explained that she thought this figure read $9,144.00, and that it already had been paid.

II. DISCUSSION

A. Federal Preemption

Connecticut General argues that the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1381, ("ERISA"), preempts all of plaintiffs' claims for relief. While under the facts of the case at hand plaintiffs initially could have sued in federal court under ERISA for benefits due and breach of fiduciary duty, they chose instead to rely solely upon state law. As explained below, plaintiffs as masters of their complaint, were free to make this

choice since their state law claims are not preempted by ERISA.

The fact that ERISA may apply to a particular dispute because the plan under scrutiny is an ERISA plan -- as is the case here -- does not by itself answer the difficult question of ERISA's effect on state law claims against an insurance company. Rather, in order to resolve this issue, it is necessary to distinguish between state laws which regulate an employee benefit plan and those which regulate an insurance company from which a plan purchases insurance. Any law directly regulating an employee benefit plan is preempted, 29 U.S.C. 1144(a), but laws regulating an insurance company or policy from an insurance company are saved from preemption. Eversole v. Metropolitan Life Insurance Co., Inc., 500 F. Supp. 1162 (C.D. CA 1980); Accord McLaughlin v. Connecticut General Life Insurance Co., 565

F. Supp. 434 (N.D. CA 1983).

Section 1144(b)(2)(A) saves from preemption state laws which "regulate insurance." The phrase "regulating the business of insurance" has been defined as "statutes aimed at protecting or regulating this relationship, directly or indirectly." See Eversole, 500 F. Supp at 1168, relying on SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969); McLaughlin, 565 F. Supp. at 443. Under the facts of the case at hand, the purpose of the state laws underlying plaintiffs' claims is to secure the insured's rights as policyholders. As a consequence, these claims should be treated as insurance regulations which are saved from preemption as was the case in Eversole and McLaughlin. This conclusion is further strengthened by § 1144(b)(2)(B), the "deemer clause." That subsection prohibits a state from deeming an employee benefit plan to be

an insurance company for the purpose of any state law regulating insurance. The effect of this clause is to prohibit a state from regulating a self-insured employee benefit plan as if it were an insurance company. Eversole, 500 F. Supp at 1169; McLaughlin, 565 F. Supp. at 443.

Russell v. Massachusetts Mutual Life Insurance Co., 722 F.2d 482 (9th Cir. 1983) does not compel a different result. In Russell the plans in question were self-funded employee benefit plans. Neither involved insurance policies. As a consequence, the savings clause of ERISA did not serve to protect the plaintiff's state law claims which were directed to the plans. In contrast, here, as in Eversole and McLaughlin, Connecticut General issued a group insurance policy to a plan. Since plaintiffs' claims are directed to this policy, the savings clause is triggered. Russell,

therefore, does not alter the rule that any law directly regulating an employee benefit plan is preempted, but laws regulating an insurance company or policy purchased from an insurance company are saved from preemption. See Eversole, 500 F. Supp. at 1170.

B. Substantive Claims

1. Coverage Under the Policy

(a) KLM Airline Ticket

Rules governing the interpretation of insurance contracts in California are well settled. First, ambiguities are construed against the insurance company. Therefore, coverage clauses are interpreted broadly in favor of coverage, while exclusions are interpreted narrowly. McLaughlin, 565 F. Supp. 434, 440 (N.D. Cal. 1983); see also State Farm Mutual Automobile Ins. Co. v. Partridge, 10 Cal.3d 94, 101-02, 109 Cal. Rptr. 811, 816 (1973). Second, if two or more interpretations are reasonable, the

court must adopt the interpretation which favors coverage. "If semantically permissible, an insurance contract will be given such interpretation as will fairly achieve its object of securing indemnity to the insured for the losses to which the insurance relates." State Farm Mutual Automobile Ins. Co. v. Jacober, 10 Cal. 3d 193, 203, 110 Cal. Rptr. 1, 7 (1973). In other words the insurer must establish that its interpretation supporting denial is the only reasonable construction of the contract. McLaughlin, 565 F. Supp. at 441. Third, the insurance contract must be considered in light of the insured's reasonable expectation of coverage. If coverage reasonably may be expected but is not to be provided, notice of noncoverage must be conspicuous, plain, and clear. Id.

Even if the ABC Trust, on behalf of its employer members, bargained for this

contract, the California rules outlined above apply to the facts of this case. See McLaughlin, 565 F. Supp. 434; Jones v. Crown Life Ins. Co., 86 Cal. App.3d 630, 150 Cal. Rptr. 375 (1978). Therefore, in order to prevail on the issue of the KLM bill, Connecticut General must show either that the clause unambiguously excludes coverage or that the clause cannot be interpreted reasonably to provide coverage. As stated above, the clause in question covers "charges for professional ambulance service to or from the nearest hospital where necessary care and treatment can be given." At various times Connecticut General contended that the claim for the KLM flight was not subject to coverage because: (1) it was a pleasure flight; (2) the services were not performed at the nearest hospital where treatment could have been provided; and (3) the treatment was not essential and

medically necessary.

The clause, however, does not specifically exclude from coverage the use of a passenger airline, does not state criteria to determine what is the nearest hospital where treatment could be received, and does not provide any guidance as to when and under what circumstances care and treatment is necessary. Furthermore, it is reasonable to interpret the clause as providing coverage for transportation upon a passenger airline to a hospital recommended by doctors for treatment which the doctors believe is essential and medically necessary. Although the doctors in San Francisco determined that Jonathan was too small and had to grow before the operation could be performed, the doctors in Holland thought that an immediate operation was necessary.

Even if the clause cannot be interpreted reasonably to provide coverage, Connecticut

General is liable for the KLM bill because it breached its contractual duty to make an adequate investigation of plaintiffs' claims. The duty to investigate possible bases for an insured's claim includes the duty to investigate grounds for denying the claim. Prior to rejecting the claim for the KLM bill, Connecticut General neither investigated whether Moffitt Hospital was the nearest hospital nor whether the treatment Jonathan was to receive there was medically necessary. For example, Connecticut General never discussed with the physicians at Moffitt Hospital or with the referring physicians in Holland the necessity of Jonathan's receiving treatment at Moffitt Hospital as opposed to a hospital in Europe. Failure to substantiate the grounds for rejection through proper investigation renders Connecticut General liable for the claim.

For either reason set forth above, Connecticut General is liable for the KLM bill. Because Hart, Shaffner & Marx has paid $698.40, its share of the KLM bill under the coordination of benefits agreement, Connecticut General is liable for 80% of the remaining sum of $2,793.60 or $2,234.88.

(b) Failure to Pay Other Claims Immediately

Page 34 of the plan booklet states: "All benefits other than disability income benefits will be paid by Connecticut General immediately upon receipt of due proof." Connecticut General breached its contract with plaintiffs by failing to comply with this term.

The evidence at trial revealed that payment on many of the other claims was delayed for over nine months. For example, the $69,141.44 issued to Children's Hospital

was not paid until Connecticut General received a collection agency claim, nine months after its receipt of the $89,840.16 bill with a balance forward of $69,141.44. Similarly, the last installment of the $89,840.16 bill in the sum of $776.00 was not paid until ten months after receipt of the bill.

Connecticut General neither has justified the delay in these payments nor has provided any rationalization for its failure to investigate in a timely fashion the status of the $69,141.40 sum. Connecticut General knew or should have known that the sum had not been paid at least as early as December 29, 1981, when it received the balance forward indication on the $89,840.16 bill. Connecticut General, therefore, breached its contract with the Kannes by failing to pay the claims "immediately upon receipt of due proof."

2. Breach of the Covenant of Good Faith and Fair Dealing

In addition to the duties imposed by the express terms of an agreement, the law in California implies in every contract a covenant of good faith and fair dealing. Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809, 157 Cal. Rptr. 482 (1979), cert. denied, 445 U.S. 912 (1980). This implied promise requires each contracting party to refrain from acting in any way that would impede the right of the other to receive the benefits of the agreement. Egan, 24 Cal.3d at 818, 169 Cal. Rptr. at 695.

Denial of a claim for insurance benefits where benefits were in fact due under an insurance contract is not, in and of itself, a breach of the implied covenant; an insurer is not required to pay every claim presented to it. Austero v. National Cas. Co., 84 Cal.App.3d 1, 30, 148 Cal.Rptr.

653, 672.

Instead, in order to be liable for breach of the implied covenant of good faith and fair dealing, Connecticut General must have acted unreasonably and in bad faith. Silberg v. California Life Ins. Co., 11 Cal.3d 452, 461, 113 Cal. Rptr. 711 (1974); Austero, 84 Cal. App.3d at 27, 148 Cal. Rptr. at 670. Bad faith, in this context, is an imprecise label for what essentially is some kind of unreasonable insurer conduct. Austero, 84 Cal.App.3d at 27 n.22, 148 Cal.Rptr. at 670 n.22. Thus, generally, the substance or gravamen of the wrong in first party insurance cases (as distinguished from third party insurance cases where the insurance company is being sued for refusing to accept the third party's offer to settle his claim) is an unreasonable refusal to pay benefits due under the terms of the policy. The benefit contracted for by an insured

under the terms of a policy is the availability of money promptly upon the occurrence of a particular event. When an insurer refuses unreasonably to make a payment of the benefit due, or when the insurer does not pay promptly, it deprives the insured of the essence of the bargain. The insured bargained for prompt payment, not a right of action against the insurer. Austero, 84 Cal. App.3d at 30, 148 Cal. Rptr. at 670.

The facts of this case go beyond the typical first party insurance case in that all but one of the claims presented (the KLM airline ticket) have been paid. Nonetheless, the test of liability in this case is the same -- whether Connecticut General's failure to investigate possible bases that may have supported plaintiffs' claims as well as its failure to pay these claims promptly was unreasonable.

From the evidence presented at trial, this Court has concluded that Connecticut General acted unreasonably in these respects. As stated previously, payment on several of the claims was delayed for over nine months. In addition, Connecticut General failed to investigate several of the claims, specifically, the KLM airline ticket, as well as the status of the $69,141.40 bill. Because Connecticut General acted in an unreasonable manner in handling plaintiffs' claims, Connecticut General breached the implied covenant of good faith and fair dealing.

This lawsuit could have been avoided had there been better communication between the parties. While both sides share responsibility for this breakdown in communication, most of the blame rests with Connecticut General, a sophisticated insurance company whose obligation is to process claims in a timely, efficient, and cordial manner.

People insure themselves for peace of mind and security. To protect these interests, it is essential that an insurer fully inquire into the possible bases that might support the insured's claim and act promptly. In this case, Connecticut General became overly pedantic and insensitive to plaintiffs during their time of great stress.

The Court does not find that the plaintiffs were negligent in the submission of their claims. While they may not have acted in strict conformity with the defendants' requirements, their failure to do so was reasonable under all of the circumstances. Early on, defendants were placed on notice that plaintiff's child was seriously ill, and would require extensive hospitalization and treatment. Repeated requests for payment of the bills were made to the claims representative, and copies of the bills were in defendants' possession. Under these

circumstances, it is not proper for the insurer to sit back and delay payment of the claims, under the pretextual theory that the plaintiffs have not dotted all the "I's" and crossed all the "T's". On the contrary, the insurer has the duty to take the initiative to see to it that the promised protection is delivered when needed. It must act to facilitate the claims instead of searching for reasons not to do so.

3. Breach of Fiduciary Duty

Plaintiffs argue that Connecticut General breached its fiduciary duties in its dealings with them. California law, however, does not recognize an action for breach of fiduciary duty between an insurer and an insured.

An insurance policy is a contract. As such, there is implied within every insurance policy a duty of good faith and fair

dealing. While this duty is fiduciary in nature, it does not create a fiduciary relationship. See, Spindle v. Chubb/Pacific Indemnity Group, 89 Cal. App.3d 706, 712, 152 Cal.Rptr. 776, 780 (1979).

In the insurance context, the implied covenant of good faith and fair dealing requires no more than "that each party is prevented from interfering with the other's right to benefit from the contract." Miller v. Elite Ins. Co., 100 Cal. App.3d 739, 756, 161 Cal. Rptr. 322, 331 (1980). It does not further require that the insurer place the insured's interests above its own as would be the case were the insured a fiduciary. The Miller court also noted that "where a conflict of interest emerges, the carrier has the obligation of protecting the interests of the insured [only] equally with his own." Miller, 100 Cal. App.3d at 756; 161 Cal. Rptr. at 331; see also, Egan

v. Mutual of Omaha Ins. Co., 24 Cal.3d at 818; 169 Cal. Rptr. at 695 (1979); Silberg, 11 Cal.3d at 460, 113 Cal. Rptr. at 717.

An insurance company, moreover, is privileged, in pursuing its own economic interests, to assert its legal rights. Fletcher v. Western National Life Insurance Co., 10 Cal. App.3d 376; 89 Cal. Rptr. 78 (1970).

> [A]n insurer is not required to pay every claim presented to it. Besides the duty to deal fairly with the insured, the insurer also has a duty to its other policyholders and to the stockholders (if it is such a company) not to dissipate its reserves through payment of meritless claims. Such a practice inevitably would prejudice the insurance seeking public because of the necessity to increase rates, and would finally drive the insurer out of business.
>
> Austero, 84 Cal. App.3d at 30, 148 Cal. Rptr. at 672.

Finally, as stated in McLaughlin:

> it strains credulity to suggest, as defendant does here, that when

> an insurance company is the fiduciary [under ERISA] making claims decisions under a group policy, that it is due the same deference accorded to trustees who have no financial interest in their decisions. There is an inherent conflict of interest between an insurance company's duties to plan participants and to its policyholders. To remedy this conflict, California insurance law holds insurers to fiduciary standards by inter alia applying strict rules of construction against the insurer. McLaughlin, 565 F.Supp at 447 n.9.

In this case this Court has applied strict rules of construction against Connecticut General in order to remedy the inherent conflict of interest between its duties to its plan participants and its duties to its policyholders. Even were Connecticut General a fiduciary under ERISA, it would not be a fiduciary under California law. Under that law, while Connecticut General is obliged to act in good faith and deal fairly, this is not a fiduciary duty.

4. Fraud

Plaintiffs' complaint alleges a cause of action for fraud based upon Connecticut General's alleged promises to them which plaintiffs claim were made without intent to perform. Specifically, plaintiffs contend that the policy contained promises that any expenses incurred by reason of Jonathan's medical problems, including his air fare from Holland to Los Angeles, would be covered in full by coordination of benefits between the various insurance companies insuring plaintiffs. Plaintiffs further contend that they were induced by these promises to purchase a policy, and also relied upon the representation to refrain from procuring other insurance.

In order to prevail on their fraud claim, plaintiffs needed to show misrepresentation, knowledge of falsity, intent to defraud -- that is, intent to induce

reliance -- justifiable reliance, and resulting damage. 4 Witkin, Summary of California Law Torts § 466 at 2711 (8th ed. 1974). The evidence at trial fails to support each of these elements. Connecticut General did not make any false representations that any medical expenses resulting from illness to Jonathan would be covered by the policy and paid promptly. The liability in this case stems from Connecticut General's failure to comply with their own internal regulations rather than from Connecticut General's intent to defraud.

5. Breach of the Statutory Duties Imposed by Insurance Code Section 790.03(h)

Plaintiffs assert that Connecticut General violated §§ 790.03(h)(2) and 790.03 (h)(3) of the Claifornia Insurance Code. These sections prohibit respectively, the failure "to acknowledge and act

reasonably promptly upon communications with respect to claims arising under insurance policies [,]" and the failure "to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies."

Connecticut General violated § 790.03(h)(2) by failing to acknowledge and act reasonably promptly upon the Kanne's claims, notwithstanding Theodore's repeated efforts to obtain payment. Theodore's many telephone calls to Connecticut General were unproductive. Eventually, he became so frustrated that following Jonathan's release from the hospital in February 1982, Theodore went to see Rosa. Although he presented to her, on that occasion, a number of the unpaid bills, which did not include the Children's Hospital bill in the sum of $69,141.40, several of these bills remained unpaid for many months thereafter.

Connecticut General, however, did not violate § 790.03(h)(3). Mr. Hanna, the Complex Manager at Connecticut General testified that Connecticut General has adopted and implemented standards for the prompt, accurate, and courteous investigation and processing of claims of policyholders. These standards are reasonable. Thus, although Rosa did not comply with these standards in handling the Kanne's claims, Connecticut General did not violate § 790.03(h)(3).

C. Exemplary And Other Damages

Were plaintiffs to have prevailed on their breach of contract claim alone, they would be entitled only to the award of compensatory damages set forth above for the KLM ticket. Civil Code § 3294 provides:

> In an action for the breach of an obligation not arising from contract, where the defendant has been guilty of oppression, fraud, or malice, express or implied, the

> plaintiff, in addition to the actual damages, may recover damages for the sake of example and by way of punishing the defendant.

Punitive damages thus are not available in an action based solely upon breach of a contractual obligation, even where the breach is intentional, willful, or in bad faith. However, where an action also sounds in tort, exemplary damages may be recovered upon proper showing of malice, fraud or oppression, even though the tort incidentally involves a breach of contract. Miller v. National American Life Insurance Co. of California, 54 Cal.App.3d 331, 336, 126 Cal. Rptr. 731, 733 (1976).

Plaintiffs, therefore, may be entitled to punitive damages on the tort theory on which they have prevailed, breach of the implied covenant of good faith and fair dealing. The mere fact that an insurer has breached its duty of good faith and fair

dealing by acting unreasonably in handling a claim, however, does not mean that the insurance company automatically is liable for exemplary damages. Austero, 84 Cal. App.3d at 36, 148 Cal. Rptr. at 676; Silberg, 11 Cal.3d at 462, 113 Cal. Rptr. at 718. Exemplary damages may be awarded only where there is oppression, fraud, malice to vex, annoy or injure, or where there is a conscious disregard of a plaintiff's rights. Miller v. Elite Insurance Co., 100 Cal. App.3d 759, 161 Cal. Rptr. 322 (1980). Thus, to be liable for punitive damages on a breach of good faith and fair dealing claim an insurer must have acted with actual malice which may be inferred from the circumstances of the case. Miller, 100 Cal. App.3d at 758, 161 Cal. Rptr. at 333, (citing Richardson v. Employer's Liability Assurance Corp., 25 Cal. App.3d 232, 245; 102 Cal. Rptr. 547, 556

(1972)); See also BAJI 6.94 and 14.71.

The evidence presented at trial established that Connecticut General acted with actual malice towards the Kannes. Connecticut General consciously disregarded the Kannes' rights by failing to process their claims in a prompt manner, by failing to investigate their claims, and by interpreting some of their claims in an unreasonable manner.

Connecticut General's breach of the implied covenant of good faith and fair dealing, and violation of Insurance Code §790.03(h)(2) were the proximate and direct cause of all loss, damage, emotional distress, embarrassment and fear of denial of medical treatment suffered by plaintiffs. Plaintiffs have suffered emotional distress, humiliation and embarrassment to their damage in the sum of $ 250,000.00 . In addition, plaintiffs are entitled to exemplary damages in the sum of $500,000.00, an amount

which the Court believes is sufficient to deter Connecticut General and other such insurance companies from treating their policyholders and insureds in the manner in which the Kanne's have been treated.

D. ATTORNEY'S FEES

In the prayer of the complaint, plaintiffs seek to recover attorney's fees as an element of damages. In California, in the absence of an attorney's fee clause in the applicable insurance policy, attorney's fees are not recoverable in a bad faith action against an insurance company. Moore v. American United Life Insurance Co., 150 Cal. App.3d 610, 644; 197 Cal. Rptr. 878, 900 (1984). The question, therefore, becomes whether or not there is an attorney's fee provision in the insurance contract between the Kannes and Connecticut General. The policy provides in pertinent part:

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

> If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area office of the U.S. Labor - Management Services Administration, Department of Labor.

This summary plan description is meant to provide policyholders with an understanding of their rights under ERISA such as those set forth in 29 U.S.C.§1132(g). That section states that: "In any action under this subchapter by a participant, beneficiary, or fiduciary, the court on its discretion may allow a reasonable attorney's fee and costs of action to either party."

Thus, although the summary plan description does not expressly restrict the Court's discretion to award attorney's fees to actions brought under ERISA, the description should be interpreted in this fashion. As

a consequence, since the Kannes chose to proceed only under state law, the Court has no power to award them attorney's fees in this action. They are, however, entitled to their costs.

LET JUDGMENT BE ENTERED ACCORDINGLY.

DATED: January 23 1985.

/s/
EDWARD RAFEEDIE
United States District Judge

FOOTNOTES

1. Although Beatriz was not covered as an eligible employee under the policy, Beatriz as Theodore's spouse is a party to the insurance contract and, therefore, has standing to sue for the claims asserted. The policy booklet states at page 4 that "you and your family members are eligible to participate in this plan . . ." and further defines family members as one's spouse. Under the policy, therefore, Beatriz is able to recover expenses incurred on behalf of a dependent to the same extent as Theodore. Moreover, it is reasonably foreseeable that Beatriz, in addition to Theodore, could suffer emotional distress from Connecticut General's improper handling of the Kanne family's claims.

2. In addition, she, at one time, told Theodore that the flight was not covered

because it was a "pleasure trip."

cf. McLaughlin v. Connecticut General, 565 F. Supp. 434, 453 (N.D. CA 1983) holding that both Mr. and Mrs. McLaughlin were parties to the insurance contract, he as the "employee" and she as his "dependent" and thus both had standing to seek damages for emotional distress and other injuries for breach of the implied covenant.

APPENDIX B

APPENDIX B

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellees,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant/Appellant,

LINCOLN NATIONAL LIFE INSURANCE COMPANY and HARLOW CARPETS, INC.,

Defendants.

No. 85-5641

D.C. No. CV 83-2261-ER

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellants,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

No. 85-5642

OPINION

Argued and Submitted
April 7, 1986-Pasadena, California
Withdrawn from Submission July 2, 1986
Resubmitted and Filed June 4, 1987

Before: Betty B. Fletcher and Harry Pregerson, Circuit Judges, and Philip C. Wilkins,* District Judge.

Per Curiam

Appeal from the United States District Court for the Central District of California Edward Rafeedie, District Judge, Presiding

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SUMMARY

Insurance

Appeal from judgment. Reversed.

This action arises from appellant Connecticut General's obligation to pay the costs for appellees' (the Kannes) son. The Kannes prevailed on two state common-law causes of action: breach of contract and breach of duty of good faith and fair dealing, and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.

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*Honorable Philip C. Wilkins, Senior United States District Judge, Eastern District of California, sitting by designation.

Connecticut General contends that these state-law claims are preempted by the Employee Retirement Income Security Act (ERISA).

[1] The Supreme Court has held that state common law causes of action asserting improper processing of a claim are preempted by federal law. [2] Reading two recent Supreme Court decisions together compels this court to conclude that the Kannes' claim that transportation costs are reimbursable under the insurance policy is also preempted.

COUNSEL

Leonard Sacks, Encino, California, Carol A. Hay, and Andrew O. Feringa, Lakewood, California, for the plaintiffs-appellees-appellants.

James S. Cline, Suzette Clover, David L. Bacon, and Bruce A. Beckman, Los Angeles, California, for the defendants-appellants-appellees.

OPINION

PER CURIAM:

Appellant Connecticut General Life Insurance Co. (Connecticut General) appeals from a judgment awarding the Kannes $252,234 in compensatory damages and $500,000 in punitive damages. The Kannes cross-appeal the denial of attorneys fees.

The Kannes brought this action, which arises out of Connecticut General's obligation to pay the costs of medical treatment for their son, Jonathan, for reimbursement for an airline fare to transport Jonathan from the Netherlands to the United States for surgery, and for compensation for the

emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The Kannes based their claims on a number of theories. They prevailed on three that are at issue on appeal: two state common-law causes of action, one for breach of contract and the other for breach of duty of good faith and fair dealing, and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.[1]

DISCUSSION

We withdrew the case from submission pending the Supreme Court's decision in Pilot Life Insurance Co. v. Dedaux, No. 85-1043 (U.S. Apr. 6, 1987), in light of

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[1]The Kannes also claimed breach of fiduciary duty, fraud, and failure to adopt reasonable standards for the processing of claims, see Cal.Ins.Code § 790.03(h)(3). They do not appeal the denial of those claims.

Connecticut General's contention at trial and before this court that the Kannes's state-law claims are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 et seq.[2] Pilot Life and a companion case, Metropolitan Life Insurance Co. v. Taylor, No. 85-686 (U.S. April 6, 1987), which also bears on the issues presented here, have now been

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[2]ERISA's relationship to state laws is governed by § 1144 of the Act. The pertinent subsections of § 1144 provide:

> (a) Except as provided in subsection (b) of this section, the provisions of [these subchapters] shall supersede any and all State laws insofar as they...relate to any employee benefit plan....
>
> (b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States....

decided. We now resubmit the case and review de novo as a matter of law the district court's conclusion that the claims were not preempted. United States v. McConney, 728 F.2d 1195 (9th Cir.) (en banc), cert. denied, 469 U.S. 824 (1984). We reverse.

[1] In Pilot Life, the Supreme Court held that state common law causes of action asserting improper processing of a claim are preempted by federal law. The Kannes' claims arising out of delay in payment are claims for improper processing and therefore are preempted. Accordingly, the judgment insofar as it awards compensatory and punitive damages arising out of the claims of delay in payment must be vacated.

[2] Reading of Pilot Life, together with Metropolitan Life, compels us to conclude that the Kannes' claim that transportation costs are reimbursable under the

insurance policy is also preempted. Because the claim "relate[s] to an employee benefit plan," see Metropolitan Life, slip op. at 4 (citing section 514(a), 29 U.S.C. § 1144(a)), it is preempted unless it is based on a law that "regulates insurance." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). California's common law of contract interpretation is not "specifically directed toward [the insurance] industry." See Pilot Life, slip op. at 8; see also Metropolitan Life, slip op. at 4. Nor generally does it effect risk spreading or concern the policy relationship between the insurer and the insured beyond that to which the parties have agreed in the insurance contract. Id. at 9. Accordingly, we conclude that California's common law of contract interpretation is not a law that "regulates insurance," and therefore is not saved from preemption.[3] The district

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[3] See p.B-52.

court's judgment based on the Kannes' claim for transportation costs must also be vacated.[4]

CONCLUSION

We resubmit this case for decision. We reverse the district court's compensatory and punitive damage awards in favor of the Kannes. We affirm the denial of attorneys fees to the Kannes.

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[3]Because we find that the law on which this claim is based does not regulate insurance, we need not consider whether the claim is in any event preempted because of the deemer clause or because it is based on a law that conflicts with federal law.

[4]Finding these claims to be preempted, we do not consider the other issues that Connecticut General has raised on appeal.

The Kannes have appealed the district court's denial of their request for attorney's fees. The California Code of Civil Procedure, section 1021, states as a general rule that parties shall bear their own costs of legal representation. See Brandt v. Superior Court, 37 Cal.3d 813, 820, 210 Cal.Rptr. 211, 214 (1985). The general rule may be altered by agreement of the parties. Id. Because the contract does not provide for the payment of attorneys fees for claims brought under state law, whether meritorious or not, we affirm this part of the district court's decision.

APPENDIX C

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellees,

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CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

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THEODORE KANNE and BEATRIZ KANNE,

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Defendant-Appellee.

No.85-5642

OPINION

Appeal from the United States District Court for the Central District of California
Edward Rafeedie, District Judge, Presiding

Argued and Submitted April 7, 1986
Pasadena, California

Withdrawn from Submission July 2, 1986
Resubmitted and Filed June 4, 1987

Petition for Rehearing granted and opinion withdrawn from submission July 23, 1987

Argued and Resubmitted November 23, 1987

Filed October 4, 1988

Before: Betty B. Fletcher and Harry Pregerson, Circuit Judges, and Philip C. Wilkins,* District Judge.

Per Curiam

SUMMARY

Insurance

Vacating a judgment, the court found an insurance policy governed and preempted by ERISA.

Appellant Connecticut General Life Insurance Co. appeals from a judgment awarding appellees Theodore and Beatriz Kanne compensatory and punitive damages. The Kannes cross-appeal the denial of attorney's fees. The

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*Hon. Philip C. Wilkins, Senior United States District Judge for the Eastern District of California, sitting by designation.

action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the U.S. for surgery, and compensation for the emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The court considers two specific issues: (1) whether the insurance policy in question is a plan governed by ERISA; and (2) whether Cal. Ins. Code § 790.03(h)(2) is preempted by ERISA. This court now concludes both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

[1] Recently, it was found that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee benefit plan. [2] The plan brochure submitted by Connecticut

General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. The ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA. [3] The Kannes and numerous amici argue that section 790.03(h) is not preempted by ERISA because the section is a law regulating insurance within the meaning of the so-called "savings clause" of ERISA. [4] To accept the Kannes' argument asking this court to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause, would have this court ignoring the second half of Pilot Life. The Supreme Court made clear that its preemption holding was equally

based on its acceptance of the Solicitor General's view that Congress clearly expressed an intent that the civil enforcement provisions of ERISA section 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. Accordingly, the Kannes' state statutory cause of action for mishandling of their insurance claim is also preempted.

COUNSEL

Leonard Sacks, Encino, California, Carol A. Hay, and Andrew O. Feringa, Lakewood, California, for the plaintiffs-appellees-appellants.

James S. Cline, Suzette Clover, David L. Bacon, and Bruce A. Beckman, Los Angeles, California, for the defendants-appellants-appellees.

OPINION

PER CURIAM:

Connecticut General Life Insurance Co. (Connecticut General) appeals from a judgment awarding Theodore and Beatriz Kanne $252,234 in compensatory damages and $500,000 in punitive damages. The Kannes cross-appeal the denial of attorneys fees.

This action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the United States for surgery, and compensation for the emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The Kannes based their claims on a number of theories and prevailed on three causes that are at issue on appeal: two state common-law causes of action (breach

of contract, and breach of the duty of good faith and fair dealing) and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.[1]

We withdrew the case from submission pending the Supreme Court's decision in Pilot Life Insurance Co. v. Dedaux, 107 S. Ct. 1549 (1987), in the expectation that Pilot Life would resolve the threshold issue of whether the Kannes' state-law claims are preempted by the Employee Retirement Income Security Act of 1974) (ERISA), 29 U.S.C. §§1001 et seq.[2] After

[1]The Kannes also claimed breach of fiduciary duty, fraud, and failure to adopt reasonable standards for the processing of claims. See Cal. Ins. Code § 790.03(h)(3). They do not appeal the denial of those claims.

[2]ERISA's relationship to state laws is governed by § 514 of the Act, 29 U.S.C. § 1144. The pertinent subsections of §514 provide:

> (a) Except as provided in subsection (b) of this section, the

(con't p. C-60)

Pilot Life and a companion case, Metropolitan Life Insurance Co. v. Taylor, 107 S.Ct. 1542 (1987), were decided, we resubmitted the case and reversed the district court's conclusion that the claims were not preempted. Kanne v. Connecticut General Life Ins. Co., Nos. 85-5641, 85-5642 (9th Cir., June 4, 1987).

We subsequently withdrew the opinion, granting the Kanne's request for rehearing, to consider two specific issues: (1) whether the insurance policy in question is a plan

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2 (con't)

> provisions of [these subchapters] shall supersede any and all State laws insofar as they...relate to any employee benefit plan....
>
> (b)(2)(A) Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States....

governed by ERISA; and (2) whether Cal. Ins. Code § 790.03(h)(2) is preempted by ERISA. We now conclude both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

DISCUSSION

I. Whether the Insurance Policy is part of an ERISA Plan

The parties at trial apparently assumed that the insurance policy was covered by ERISA. Little or no attention was paid to the issue. The plan brochure, introduced by Connecticut General as an exhibit at trial, describes the plan as an ERISA plan. The Associated Builders and Contractors (ABC), an employer group to which Harlow Carpets belongs, is described as the Administrator of the plan. Harlow Carpets subscribed to the group health insurance plan

administered by ABC. Pursuant to the requirements of ERISA, the plan was established as a trust entity, called the ABC Trust. It purchased a policy of group health insurance from Connecticut General.[3] Theodore Kanne was an employee of Harlow Carpets and was covered by the policy.

Under ERISA § 3(1), 29 U.S.C. § 1002(1), an "employee welfare benefit plan" or "Welfare plan" is:

> (1) a "plan, fund or program"
> (2) established or maintained
> (3) by an employer or by an employee organization, or by both,
> (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to the participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982)(en banc).

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[3]Prior to 1981, Harlow Carpets had subscribed to an insurance plan directly with Connecticut General, but then changed to the ABC plan.

[1] The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person. Credit Managers Ass'n v. Kernesan Life & Accident Ins. Co., 809 F.2d 617, 625 (9th Cir. 1987). At trial, the parties did not contest the issue of whether the ABC Trust was an ERISA plan. However, in the wake of the broad holding of Pilot Life, that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee benefit plan, the question of whether the policy here is governed by ERISA takes on vital importance to the Kannes, who now contest that an ERISA plan existed.

The Department of Labor has issued regulations excluding certain group insurance programs from ERISA's definition of "Employee welfare benefit plan":

(j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation in the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j)(1987). A bare purchase of insurance, without any of the above

elements present, does not by itself constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan). See Donovan v. Dillingham, 688 F.2d at 1375. An employer has not established an ERISA plan if it merely advertises a group insurance plan that has none of the attributes described in 29 C.F.R. § 2510.3-1(j). See Credit Managers Ass'n., 809 F.2d at 625.

The Kannes argue that, in respect to the group insurance at issue here, there is no evidence of the existence of the four criteria under 29 C.F.R. § 2510.3-1(j), any one of which would prevent the exclusion of the insurance plan from ERISA coverage.[4] It is true that the record is ambiguous as to whether Harlow Carpets ever contributed

[4]Because Connecticut General's claim of ERISA preemption is a federal defense in this lawsuit, Metropolitan Life Ins. Co. v. Taylor, 107 S.Ct. at 1546, the burden is on the defendant to prove the facts necessary to establish it.

any payments towards Theodore Kanne's insurance coverage or whether Kanne's participation was voluntary or automatic. Harlow Carpets' function with respect to the program was minor and ministerial, and no evidence indicates whether the plan was administered by a profit-making concern.

However, the problem with the Kannes' argument is their apparent assumption that Harlow Carpets' functions with respect to the plan determine ERISA coverage. According to ERISA § 3(5):

> The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5)(emphasis added). Under this definition, ABC can be an ERISA employer for purposes of our analysis.

[2] The plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. It is clear that, at a minimum, ABC does not merely advertise the group insurance, but rather, as the administrator of the plan, "endorses" it within the meaning of 29 C.F.R. § 2510.3-1(j)(3). Thus the ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA. See Credit Managers Ass'n, 809 F.2d at 625.

II. Whether ERISA Preempts the Kannes' State Law Claims

In Pilot Life, the Supreme Court held that state common law causes of action arising from the improper processing of a claim

are preempted by federal law. The Kannes' claims arising out of delay in payment are claims for improper processing and therefore are preempted. Accordingly, the judgment insofar as it awards compensatory and punitive damages arising out of the common law claims for delay in payment must be vacated.

We must also decide whether ERISA preempts the Kannes' state statutory claims for compensatory and punitive damages arising from delay in payment. California Insurance Code § 790.03(h) prohibits various "unfair insurance practices" having to do with the processing of claims. Among these unfair practices is an insurer's failure "to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." §790.03(h)(2). At the time relevant to this appeal § 790.03(h) created a private right of action. Royal Globe Ins. Co. v.

Superior Court, 23 Cal.3d 880, 886, 153 Cal. Rptr. 842, 846 (1979), overruled by Moradi-Shalal v. Fireman's Fund Ins. Co., ___ Cal. 3d ___ (Cal. Aug. 18, 1988).[5] The district court found that Connecticut General had violated subsection (h)(2), giving rise to a cause of action in the Kannes.

[3] The Kannes and numerous amici argue virorously that § 790.03(h) is not pre-empted by ERISA because § 790.03(h) is a law regulating insurance within the meaning of the so-called "savings clause," § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

[5]The Moradi-Shalal court held that the Royal Globe rule would continue to apply to all cases filed prior to the Moradi-Shalal decision. ___ Cal.3d at ___.

The Kannes and the amici point out that the preempted common law causes of action for bad faith in Pilot Life were held not to be laws regulating insurance within the savings clause. They argue that because § 790.03(h) regulates insurance, the savings clause saves that provision from preemption. We can assume, without deciding, that § 790.03 (h) is a law regulating insurance under the savings clause. Noevertheless, under Pilot Life we find the conclusion inescapable that § 790.03(h) is preempted by ERISA.[6]

[4] The Kannes' argument asks us to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause. To accept this argument,

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[6]A handful of cases in federal district courts in California have by now been decided, reaching differing results. We find ourselves most in agreement with the well-reasoned opinion in Roberson v. Equitable Life Assurance Soc., 661 F.Supp. 416, 423-24 (C.D. Cal. 1987).

however, we would have to ignore the second half of Pilot Life, 107 S.Ct. 1555-58, in which the Court made abundantly clear that its preemption holding was equally based on its acceptance of the Solicitor General's view that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." Id. at 1555. The Court stated:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress had rejected in ERISA.

Id. at 1556. We do not find it possible to read this language in a way that permits a state statute like § 790.03(h) to supplement the ERISA civil enforcement provisions available to remedy improper claims processing. Accordingly, the Kannes state statutory cause of action for mishandling of their insurance claim is also preempted.

Finally,we must consider whether the Kannes' claim for reimbursement of transportation costs is preempted. Because the claim "relate[s] to an employee benefit plan," see Metropolitan Life, 107 S.Ct. at 1546 (citing section 514(a), 29 U.S.C. § 1144(a)), it is preempted unless it is based on a law that "regulates insurance." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). The Kannes' claim for reimbursement is premised on the interpretation of their insurance contract. However, California's common law of contract interpretation is not

"specifically directed toward [the insurance] industry." See Pilot Life, 107 S.Ct. at 1555; see also Metropolitan Life, 107 S.Ct. at 1546. Nor generally does it effect risk spreading or concern the policy relationship between the insurer and the insured beyond that to which the parties have agreed in the insurance contract. Pilot Life, 107 S.Ct. at 1554-55. Accordingly, we conclude that Californaia's common law of contract interpretation is not a law that "regulates insurance," and therefore is not saved from preemption.[7] The district court's judgment based on the Kannes' claim for transportation costs must also be vacated.[8]

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[7] Because we find that the law on which this claim is based does not regulate insurance, we need not consider whether the claim is in any event preempted because of the deemer clause or because it is based on a law that conflicts with federal law.

[8] Finding these claims to be preempted, we do not consider the other issues that Connecticut General has raised on appeal.

(cont. p. C-74)

CONCLUSION

We find that the Kannes' group health insurance policy with Connecticut General is part of an ERISA plan. We hold that each of their state common-law and statutory causes of action is preempted by ERISA. Accordingly, we VACATE the judgment of the district court insofar as it awards damages in favor of the plaintiffs.

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[8](cont.)

The Kannes have appealed the district court's denial of their request for attorney's fees. The California Code of Civil Procedure, section 1021, states as a general rule that parties shall bear their own costs of legal representation. See Brandt v. Superior Court, 37 Cal.3d 813, 820, 210 Cal. Rptr. 211, 214 (1985). The general rule may be altered by agreement of the parties. Id. Because the contract does not provide for the payment of attorneys fees for claims brought under state law, whether meritorious or not, we affirm this part of the district court's decision.

APPENDIX D

APPENDIX D

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellees,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellant,

LINCOLN NATIONAL LIFE INSURANCE COMPANY and HARLOW CARPETS, INC.,

Defendants.

No.85-5641

D.C.No. CV83-2261-ER

THEODORE KANNE and BEATRIZ KANNE,

Plaintiffs-Appellants,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

No.85-5642

ORDER AND AMENDED OPINION

Appeal from the United States District Court for the Central District of California
Edward Rafeedie, District Judge, Presiding

Argued and Submitted
April 7, 1986--Pasadena, California

Withdrawn from Submission July 2, 1986
Resubmitted and Filed June 4, 1987

Petition for Rehearing granted and opinion withdrawn from submission July 23, 1987

Argued and Resubmitted November 23, 1987

Filed October 4, 1988
Amended February 2, 1989

Before: Betty B. Fletcher and Harry Pregerson, Circuit Judges, and Philip C. Wilkins,* District Judge.

Per Curiam

SUMMARY

Insurance

Vacating a judgment, the court found an insurance policy governed and preempted by ERISA.

Appellant Connecticut General Life Insurance Co. appeals from a judgment awarding appellees Theodore and Beatriz Kanne compensatory and punitive damages. The Kannes

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*Hon. Philip C. Wilkins, Senior United States District Judge for the Eastern District of California, sitting by designation.

cross-appeal the denial of attorney's fees. The action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the U.S. for surgery, and compensation for the emotional distress caused them by the delay in payments for the airline, physician, and hospital bills. The court considers two specific issues: (1) whether the insurance policy in question is a plan governed by ERISA; and (2) whether Cal. Ins. Code § 790.03(h)(2) is preempted by ERISA. This court now concludes both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

[1] Recently, it was found that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee benefit plan. [2] The

plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. The ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need not be employer contributions or automatic employee coverage to bring the plan within ERISA. [3] The Kannes and numerous amici argue that section 790.03(h) is not preempted by ERISA because the section is a law regulating insurance within the meaning of the so-called "savings clause" of ERISA. [4] To accept the Kannes' argument asking this court to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause, would have this court ignoring the second half of Pilot Life. The Supreme Court made clear

that its preemption holding was equally based on its acceptance of the Solicitor General's view that Congress clearly expressed an intent that the civil enforcement provisions of ERISA section 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. Accordingly, the Kannes' state statutory cause of action for mishandling of their insurance claim is also preempted.

COUNSEL

Leonard Sacks, Encino, California, Carol A. Hay, and Andrew O. Feringa, Lakewood, California, for the plaintiffs-appellees-appellants.

James S. Cline, Suzette Clover, David L. Bacon, and Bruce A. Beckman, Los Angeles, California, for the defendants-appellants-appellees.

ORDER

We hereby amend the opinion Filed October 4, 1988.

In the middle paragraph of slip opinion at page 12500, the final sentence is changed to read:

> Nevertheless, under Pilot Life we find the conclusion inescapable that the private right of action for violation of §790.03(h) is preempted by ERISA.

Footnote 6 is amended by adding the sentence:

> We express no opinion as to whether the substantive provisions of § 790.03(h) are themselves pre-empted so as to bar administrative enforcement by California's Insurance Commissioner.

With this amendment, the panel has voted to deny the petition for rehearing. The full court has been advised of the amendment to the opinion and the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the

matter en banc. (Fed. R. App. P. 35.)

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

OPINION

PER CURIAM:

Connecticut General Life Insurance Co. (Connecticut General) appeals from a judgment awarding Theodore and Beatriz Kanne $252,234 in compensatory damages and $500,000 in punitive damages. The Kannes cross-appeal the denial of attorney's fees.

This action arises out of Connecticut General's medical coverage of the Kannes' son Jonathan. The Kannes seek reimbursement for an airline fare to transport Jonathan from the Netherlands to the United States for surgery, and compensation for the emotional distress caused them by the delay in

payments for the airline, physician, and hospital bills. The Kannes based their claims on a number of theories and prevailed on three causes that are at issue on appeal: two state common-law causes of action (breach of contract, and breach of the duty of good faith and fair dealing) and one statutory cause of action under the California Insurance Code for failure to pay claims reasonably promptly.[1]

We withdrew the case from submission pending the Supreme Court's decision in Pilot Life Insurance Co. v. Dedeaux, 107 S.Ct. 1549 (1987), in the expectation that Pilot Life would resolve the threshold issue of whether the Kannes' state-law claims are preempted by the Employee

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[1]The Kannes also claimed breach of fiduciary duty, fraud, and failure to adopt reasonable standards for the processing of claims. See Cal.Ins.Code § 790.03(h)(3). The do not appeal the denial of those claims.

Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq.[2] After Pilot Life and a companion case, Metropolitan Life Insurance co. v. Taylor, 107 S.Ct. 1542 (1987), were decided, we resubmitted the case and reversed the district court's conclusion that the claims were not preempted. Kanne v. Connecticut General Life

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[2]ERISA's relationship to state laws is governed by § 514 of the Act, 29 U.S.C. § 1144. The pertinent subsections of § 514 provide:

> (a) Except as provided in subsection (b) of this section, the provisions of [these subchapters] shall supersede any and all State laws insofar as they...relate to any employee benefit plan....
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> (b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
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Ins. Co., Nos. 85-5641, 85-5642 (9th Cir. June 4, 1987).

We subsequently withdrew the opinion, granting the Kannes' request for rehearing, to consider two specific issues: (1) whether the insurance policy in question is a plan governed by ERISA; and (2) whether Cal.Ins. Code § 790.03(h)(2) is preempted by ERISA. We now conclude both that the Kannes' insurance policy is an ERISA plan and that their claims against Connecticut General are preempted.

DISCUSSION

I. Whether the Insurance Policy is Part of an ERISA Plan

The parties at trial apparently assumed that the insurance policy was covered by ERISA. Little or no attention was paid to the issue. The plan brochure, introduced by Connecticut General as an exhibit at

trial, describes the plan as an ERISA plan. The Associated Builders and Contractors (ABC), an employer group to which Harlow Carpets belongs, is described as the Administrator of the plan. Harlow Carpets subscribed to the group health insurance plan administered by ABC. Pursuant to the requirements of ERISA, the plan was established as a trust entity, called the ABC Trust. It purchased a policy of group health insurance from Connecticut General.[3] Theodore Kanne was an employee of Harlow Carpets and was covered by the policy.

Under ERISA § 3(1), 29 U.S.C. § 1002(1), an "employee welfare benefit plan" or "welfare plan" is:

> (1) a "plan, fund or program"
> (2) established or maintained
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[3]Prior to 1981, Harlow Carpets had subscribed to an insurance plan directly with Connecticut General, but then changed to the ABC plan.

> employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to the participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982)(en banc).

[1] The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person. Credit Managers Ass'n v. Kernesan Life & Accident Ins. Co., 809 F.2d 617, 625 (9th Cir. 1987). At trial, the parties did not contest the issue of whether the ABC Trust was an ERISA plan. However, in the wake of the broad holding of Pilot Life, that ERISA preempts state law causes of action pertaining to improper handling of insurance claims under an employee

benefit plan, the question of whether the policy here is governed by ERISA takes on vital importance to the Kannes, who now contest that an ERISA plan existed.

The Department of Labor has issued regulations excluding certain group insurance programs from ERISA's definition of "employee welfare benefit plan":

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> (1) No contributions are made by an employer or employee organization;
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> (2) Participation in the program is completely voluntary for employees or members;
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> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs

> and to remit them to the insurer; and
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> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29C.F.R. § 2510.3-1(j)(1987). A bare purchase of insurance, without any of the above elements present, does not by itself constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan). See Donovan v. Dillingham, 688 F.2d at 1375. An employer has not established and ERISA plan if it merely advertises a group insurance plan that has none of the attributes described in 29 C.F.R. § 2510.3-1(j). See Credit Managers Ass'n, 809 F.2d at 625.

The Kannes argue that, in respect to the group insurance at issue here, there is no evidence of the existence of the four

criteria under 29 C.F.R. § 2510.3-1(j), any one of which would prevent the exclusion of the insurance plan from ERISA coverage.[4] It is true that the record is ambiguous as to whether Harlow Carpets ever contributed any payments towards Theodore Kanne's insurance coverage or whether Kanne's participation was voluntary or automatic. Harlow Carpets' function with respect to the program was minor and ministerial, and no evidence indicates whether the plan was administered by a profit-making concern.

However, the problem with the Kannes' argument is their apparent assumption that Harlow Carpets' functions with respect to the plan determine ERISA coverage. According to ERISA § 3(5):

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[4]Because Connecticut General's claim of ERISA preemption is a federal defense in this lawsuit, Metropolitan Life Ins. Co. v. Taylor, 107 S.Ct. at 1546, the burden is on the defendant to prove the facts necessary to establish it.

> The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5)(emphasis added). Under this definition, ABC can be an ERISA employer for purposes of our analysis.

[2] The plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan. It is clear that, at a minimum, ABC does not merely advertise the group insurance, but rather, as the administrator of the plan, "endorses" it within the meaning of 29 C.F.R. § 2510.3-1(j)(3). Thus the ABC plan is not one of the group insurance programs excluded by ERISA under the regulations. Because ABC is more than a mere advertiser of group insurance, there need

not be employer contributions or automatic employee coverage to bring the plan within ERISA. See Credit Managers Ass'n, 809 F.2d at 625

II. Whether ERISA Preempts the Kannes' State Law Claims

In Pilot Life, the Supreme court held that state common law causes of action arising from the improper processing of a claim are preempted by federal law. The Kannes' claims arising out of delay in payment are claims for improper processing and therefore are preempted. Accordingly, the judgment insofar as it awards compensatory and punitive damages arising out of the common law claims for delay in payment must be vacated.

We must also decide whether ERISA preempts the kannes' state statutory claims for compensatory and punitive damages arising

from delay in payment. California Insurance Code § 790.03(h) prohibits various "unfair insurance practices" having to do with the processing of claims. Among these unfair practices is an insurer's failure "to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." §790.03(h)(2). At the time relevant to this appeal §790.03 (h) created a private right of action. Royal Globe Ins. Co. v. Superior Court, 23 Cal.3d 880, 886, 153 Cal. Rptr. 842, 846 (1979), overruled by Moradi-Shalal v. Fireman's Fund Ins. Co., ___ Cal.3d ___ (Cal. Aug. 18, 1988).[5] The district court found that Connecticut General had violated subsection (h)(2), giving rise to a cause of action in the Kannes.

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[5]The Moradi-Shalal court held that the Royal Globe rule would continue to apply to all cases filed prior to the Moradi-Shalal decision. ___ Cal.3d at ___.

[3] The Kannes and numerous amici argue vigorously that § 790.03(h) is not preempted by ERISA because § 790.03(h) is a law regulating insurance within the meaning of the so-called "savings clause," § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which provides

> Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

The Kannes and the amici point out that the preempted common law causes of action for bad faith in Pilot Life were held not to be laws regulating insurance within the savings clause. They argue that because § 790.03(h) regulates insurance, the savings clause saves that provision from preemption. We can assume, without deciding, that § 790.03(h) is a law regulating insurance under the savings clause. Nevertheless,

under Pilot Life we find the conclusion inescapable that the private right of action for violation of § 790.03(h) is preempted by ERISA.[6]

[4] The Kannes' argument asks us to limit Pilot Life's preemption holding to only those state laws which do not fall within the savings clause. To accept this argument however, we would have to ignore the second half of Pilot Life, 107 S.Ct. 1555-58, in which the Court made abundantly clear that its preemption holding was equally based on its acceptance of the Solicitor General's view that "Congress clearly

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[6]A handful of cases in federal district courts in California have by now been decided, reaching different results. We find ourselves most in agreement with the well-reasoned opinion in Roberson v. Equitable Life Assurance Soc., 661 F.Supp. 416, 423-24 (C.D.Cal. 1987). We express no opinion as to whether the substantive provisions of §790.03(h) are themselves preempted so as to bar administrative enforcement by California's Insurance Commissioner.

expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." Id. at 1555. The Court stated:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress had rejected in ERISA.

Id. at 1556. We do not find it possible to read this language in a way that permits a state statute like § 790.03(h) to supplement the ERISA civil enforcement provisions available to remedy improper claims processing.

Accordingly, the Kannes' state statutory cause of action for mishandling of their insurance claim is also preempted.

Finally, we must consider whether the Kannes' claim for reimbursement of transportation costs is preempted. Because the claim "relate[s] to an employee benefit plan." see Metropolitan Life, 107 S.Ct. at 1546 (citing section 514(a), 29 U.S.C. § 1144(a)), it is preempted unless it is based on a law that "regulates insurance." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). The Kannes' claim for reimbursement is premised on the interpretation of their insurance contract. However, California's common law of contract interpretation is not "specifically directed toward [the insurance] industry." See Pilot Life, 107 S.Ct. at 1555; see also Metropolitan Life, 107 S.Ct. at 1546. Nor generally does it effect risk spreading or concern the policy

relationship between the insurer and the insured beyond that to which the parties have agreed in the insurance contract. Pilot Life, 107 S.Ct. at 1554-55. Accordingly, we conclude that California's common law of contract interpretation is not a law that "regulates insurance," and therefore is not saved from preemption.[7] The district court's judgment based on the Kannes' claim for transportation costs must also be vacated.[8]

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[7]Because we find that the law on which this claim is based does not regulate insurance, we need not consider whether the claim is in any event preempted because of the deemer clause or because it is based on a law that conflicts with federal law.

[8]Finding these claims to be preempted, we do not consider the other issues that Connecticut General has raised on appeal.

The Kannes have appealed the district court's denial of their request for attorney's fees. The California Code of Civil Procedure, section 1021, states as a general rule that parties shall bear their own costs of legal representation. See Brandt v. Superior Court, 37 Cal.3d 813, 820, 210 Cal.Rptr. 211, 214 (1985). The general

(cont. p. D-98)

CONCLUSION

We find that the Kannes' group health insurance policy with Connecticut General is part of an ERISA plan. We hold that each of their state common-law and statutory causes of action is preempted by ERISA. Accordingly, we VACATE the judgment of the district court insofar as it awards damages in favor of the plaintiffs.

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8 (cont.)

rule may be altered by agreement of the parties. Id. Because the contract does not provide for the payment of attorneys fees for claims brought under state law, whether meritorious or not, we affirm this part of the district court's decision.

APPENDIX E

APPENDIX E

29 U.S.C. Section 1144(b)(2)(A) provides:

"(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

29 U.S.C. Section 1003(a) provides:

"(a) Except as provided in subsection (b) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained--

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees

engaged in commerce or in any industry or activity affecting commerce; or

(3) by both."

29 U.S.C. Section 1002(5) provides,

"For Purposes of this subchapter":

. . .

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. Section 1131 provides:

"Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than $5,000 or

imprisoned not more than one year, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding $100,000."

Department of Labor Regulation 29 CFR Section 2510.3-1(j) provides:

"(j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) The Participation in the program is competely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs."

California Insurance Code Section 790.03(h)(2) provides:

"The following are hereby defined as

unfair methods of competition and unfair and deceptive acts of practices in the business of insurance.

. . .

(h) Knowingly committing or performing with such frequeny as to indicate a general business practice any of the following unfair claims settlement practices:

. . .

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

Supreme Court, U.S.
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No. 88-1659

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. (202) 347-8203

Questions Presented

1. Should this Court review the question whether the exclusive federal civil enforcement remedies established by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, preempt a private right of action for improper processing of claims that was implied under a provision of California law that the California Supreme Court has now decided was never intended to create a private civil cause of action?

2. Should this Court review the question whether the medical benefits plan in this case is an employee benefit plan governed by ERISA despite determinations on the available record by both the district court and the court of appeals that it is such a plan and despite the failure by petitioners to dispute the existence of an ERISA plan until their petition for rehearing in the court of appeals?*

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* The parent company of respondent Connecticut General Life Insurance Company is Connecticut General Corporation. The parent of Connecticut General Corporation is CIGNA Holdings, Inc., the parent of which is CIGNA Corporation. Connecticut General's affiliates and subsidiaries (other than wholly owned subsidiaries) are Apollo Computers, Inc., Greenspoint Marriott Restaurant Corporation, Lotus Development Corp., Maritime Beverages Limited, North Coast Investment Corporatin, PCGP, Inc., Reflectone, Inc., River Oaks Industries, Inc., Sterling Chemicals, Inc.

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IN THE

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OCTOBER TERM, 1988

No. 88-1659

THEODORE KANNE and
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v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

Respondent, Connecticut General Life Insurance Company, respectfully requests that this Court deny the petition for writ of certiorari seeking review of the Ninth Circuit's decision in this case. That decision, as amended, is reported at 867 F.2d 489 (1989).

STATEMENT OF THE CASE

Respondent does not deem it necessary to set forth detailed corrections to the petitioners' statement of the case. Rather, for purposes of this brief in opposition, respondent simply relies on the court of

appeals' statement of the case, *see* 867 F.2d, at 491, and the following brief statement.

In 1982, the Kannes initiated a suit against Connecticut General in the California Superior Court for improper processing of claims relating to the treatment of their son. The Kannes' complaint sought compensatory and punitive damages on the basis of several common law causes of action as well as an implied private right of action under Cal. Ins. Code § 790.03 (Deering Supp. 1989) ("Section 790.03"). No recovery was sought under the applicable provisions of the Employee Retirement Income Security Act ("ERISA").

The case was removed to federal court on the basis of diversity of citizenship. Connecticut General asserted ERISA defenses in its answer, and throughout the district court proceedings took the position that ERISA preempted all of the Kannes' state law claims. After a non-jury trial, the district court found that "the plan under scrutiny is an ERISA plan." 607 F. Supp. 899, 904 (C.D. Cal. 1985). However, the court held that the Kannes' claims were not preempted by ERISA because the Kannes' common law and statutory claims were saved from preemption by 29 U.S.C. § 1144(b)(2)(A) as laws that regulate insurance. The court awarded the Kannes $250,000 for emotional distress and embarrassment and $500,000 in punitive damages for breach of an implied covenant of good faith and fair dealing and violation of the California Insurance Code.

Connecticut General appealed to the Ninth Circuit. The case was argued and submitted, but withdrawn pending this Court's decision in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987). After *Pilot Life*

was decided, the court of appeals reviewed *de novo* the district court's conclusion that the Kannes' claims were not preempted by ERISA. It held that "[b]ecause the claim 'relate[s] to an employee benefit plan," all of the Kannes' state law claims were preempted. 819 F.2d 204 (9th Cir. 1987) (*quoting Metropolitan Life Insurance Co.* v. *Taylor*, 107 S. Ct. 1542, 1546 (1987)). The district court's decision was accordingly reversed.

The Kannes petitioned for rehearing, arguing that the court of appeals erred in holding that *Pilot Life* required preemption of their statutory as well as common law claims, and raising for the first time the contention that the insurance policy in question was not the funding mechanism for a plan governed by ERISA. The court granted the Kannes' petition, and permitted the Kannes to brief the questions (1) whether ERISA governed the relevant plan and (2) whether ERISA preempted the cause of action implied under Section 790.03. 823 F.2d 284 (9th Cir. 1987). The court answered both questions affirmatively. *See* 859 F.2d 96 (9th Cir. 1988), *as amended* 867 F.2d 489 (9th Cir. 1989).

REASONS WHY THE PETITION SHOULD BE DENIED

I

The First Question Does Not Present an Issue of General Importance Nor Is It a Source of Conflict Among the Circuits

The first question presented in the Petition is whether ERISA preempts the private cause of action previously available under Section 790.03. Following this Court's decision in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), the Ninth Circuit held both initially and on rehearing that the petitioners'

implied cause of action under Section 790.03 was preempted by ERISA. Petitioners claim that this question "is of tremendous importance" and that "it is urgent that this Court resolve this issue." Pet. at 22. Apart from noting the obvious correctness of the Ninth Circuit's resolution of this question under *Pilot Life*, discussed in Part III hereof, it is respectfully submitted that there is no conflict among the Circuits on this issue and, even if this question was ever of any importance, it is no longer of any importance because the California Supreme Court has now held that Section 790.03 was never intended to create a private right of action.

In *Royal Globe Insurance Co.* v. *Superior Court*, 23 Cal. 3d 880, 592 P.2d 329 (1979), a closely divided California Supreme Court held that a private right of action for damages for unfair claims practices could be implied from Section 790.03. Thus, one of the bases for recovery asserted by the Kannes in their original complaint was that Connecticut General had failed to comply with Section 790.03. After the Ninth Circuit found this action to be preempted by ERISA but before it reaffirmed its conclusion on rehearing, the California Supreme Court overruled *Royal Globe*, holding squarely that Section 790.03 was not "intended to create a private civil cause of action against an insurer" for unfair claims practices. *See Moradi-Shalal* v. *Fireman's Fund Insurance Co.*, 46 Cal. 3d 287, 304, 758 P.2d 58, 68 (1988). Although the California Supreme Court held that its decision would be applied prospectively "in the interest of fairness to the substantial number of plaintiffs who have already initiated their suits in reliance on *Royal Globe*," *id.*, at 305, 758 P.2d, at 69, the question petitioners seek

to have reviewed by this Court will have no significance for any case initiated after the *Moradi-Shalal* decision.

Petitioners seek to minimize the significance of this development by stating that because the *Moradi-Shalal* decision applies prospectively, it "does not affect the large number of pending cases asserting causes of action under California Insurance Code Section 790.03(h)." Pet. at 26. Even if true, this assertion does little to enhance the importance of the question petitioners present in their Petition. Petitioners never explain why a question that affects only a limited number of cases and that will not arise in the future is of sufficient importance to warrant review by this Court. The Ninth Circuit's decision does not conflict with the decision of another federal court of appeals or with the decision of the state court of last resort, in this case the California Supreme Court. On the contrary, the California Supreme Court, like the Ninth Circuit, has concluded that ERISA preempts Section 790.03 causes of action. *See Commercial Life Insurance Co.* v. *Superior Court*, 47 Cal. 3d 473, 764 P.2d 1059 (1988), *cert. denied sub nom. Juliano* v. *Commercial Life Insurance Co.*, 57 U.S.L.W. 3753 (U.S. May 15, 1989).[1] Thus, the highest federal and state courts that have considered the question—the judicial bodies most familiar with Section 790.03 and with the cases pending that present this question—have

[1] The question presented in the *Juliano* petition was virtually identical to the first question presented by petitioners in this case. That the Court so recently denied review in *Juliano* confirms that the first question presented does not warrant review by this Court.

reached the same conclusion as to the effect of ERISA on Section 790.03.[2]

Perhaps recognizing the relatively narrow significance of the first question presented, petitioners state that "[n]umerous other states have laws which seek to deter unfair insurance practices by assessing various penalties." Pet. at 26. This observation is significant, according to petitioners, because such statutes "will be rendered a nullity under the *Kanne* Court's interpretation of this Court's decision in *Pilot Life*." Pet. at 28. This suggestion is simply incorrect. The Ninth Circuit held only that ERISA preempts Section 790.03 causes of action. Although the court's reasoning may apply with equal persuasive force to other states' laws, the decision in *Kanne* will not *ipso facto* control the disposition in such cases. In any given case, the preemption inquiry must inevitably involve consideration of the unique characteristics of the state law in question. *See Pilot Life*, 481 U.S., at 50-51 (relevant consideration is whether the means of enforcing the law in question conflicts with ERISA's exclusive federal remedies for plan participants, an inquiry requiring examination of the intent and impact of the law in question).

Since private causes of action like the one held to be preempted in this case are no longer available

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[2] Other courts of appeals have found preemption of private causes of action under state laws similar to Section 790.03. *See In re Life Insurance Company of North America*, 857 F.2d 1190 (8th Cir. 1988) (ERISA preempts private cause of action for vexatious refusal to pay insurance benefits under Mo. Rev. Stat. § 375.420); *Anschultz* v. *Connecticut General Life Insurance Co.*, 850 F.2d 1467 (11th Cir. 1988) (ERISA preempts private cause of action under Fla. Stat. § 624.155).

under Section 790.03, this case is an obviously inappropriate vehicle for this Court's examination of the validity of other state statutory causes of action even if the Court were inclined to undertake such an abstract inquiry. The Court should not do so. Deciding whether ERISA preempts causes of action under other states' statutes should await cases actually involving those statutes.

II

Petitioners Did Not Properly Raise or Preserve the Second Question Presented

The second question presented in the Petition is whether the medical benefits plan in this case is an employee benefit plan governed by ERISA. The petitioners assert that several courts of appeals have adopted varying criteria for determining the existence of an ERISA plan, and that it is important for this Court to review the Ninth Circuit's determination. *See* Pet. at 41. However, this case presents an especially inappropriate vehicle for providing meaningful review of this highly fact-specific question. Therefore, even assuming that the petitioners are correct in predicting that there will be other Petitions seeking review of this issue filed in this Court, there is no reason to review it in this case.

From the time it answered the complaint, and throughout the proceedings, Connecticut General took the position that the Kannes' claim was for the enforcement of rights under an ERISA plan and that their exclusively state law claims were preempted by ERISA. As the petitioners themselves acknowledge, they did not dispute that the plan in question was an ERISA plan until after the district court had found,

after trial, that the plan under scrutiny was an ERISA plan and the court of appeals had ruled that ERISA preempted their claims. Petitioners did not contest the existence of an ERISA plan until they filed their petition for rehearing in the court of appeals. The court of appeals granted the petition and ruled, as had the trial court, that the plan was indeed governed by ERISA.[3] Having failed to dispute the existence of an ERISA plan at trial or even initially in the court of appeals, petitioners are in no position to ask this Court to review the Ninth Circuit's decision on the ground that the decision "is not supported by any evidence." Pet. at 20; *see id.*, at 49-50. Presumably, petitioners would have this Court vacate the Ninth Circuit's decision and remand the case for a re-determination of this issue by the trial court after receiving whatever additional unspecified evidence petitioners would, in the eleventh hour of this litigation, decide to place in the record. Such is not the function of this Court's discretionary jurisdiction.

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[3] Because both the district court and the court of appeals found the plan in question to be an ERISA plan, application of the "two court rule" precludes review by this Court "in the absence of a very obvious and exceptional showing of error." *Graver Tank & Mfg. Co.* v. *Linde Air Products Co.*, 336 U.S. 271, 275 (1949). Petitioners have made no such showing.

It is no objection that the determination in question may be characterized as a "mixed" question of law and fact, because the "two court rule" has been applied to analogous determinations. *See, e.g., United States* v. *Doe*, 465 U.S. 605, 613-614 (1984) ("two court rule" applied to finding that act of producing certain documents would constitute testimonial self-incrimination); *Graver Tank Mfg. Co.* v. *Linde Air Products Co.*, 336 U.S. 271, 274-75 (1949) ("two court rule" applied to determination that welding process constituted patentable invention).

Petitioners argue that the Ninth Circuit's "opinion acknowledges that at the trial 'the parties did not contest the issue of whether the ABC Trust was an ERISA plan.' " Pet. at 19-20 (emphasis in original) (*quoting Kanne*, 867 F.2d, at 492). From this, petitioners infer that therefore "*this issue was never litigated.*" Pet. at 20. But the fact is that the issue was litigated, but *not contested.* To the extent that petitioners failed to preserve the ERISA plan question properly below, this case is simply unsuited for review by this Court.

In this case, the issue was presented below, but not contested by petitioners until it was obvious to them that their other legal arguments were foreclosed by a decision of this Court. Therefore, petitioners' failure to dispute the existence of an ERISA plan in the district court led to the purported lack of evidence which, they now say, undermines the Ninth Circuit's decision rejecting their claim. Thus, even if the record below contains less evidence on this question than the petitioners would prefer,[4] the state of the record is directly attributable to presumably intentional tactical decisions by petitioners, decisions which preclude intervention at this stage by this Court. In effect, petitioners are seeking a writ of certiorari not to have this Court decide an important question of law, but to have the Court remand a question to the district court—the court in which petitioners should have litigated this question in the first instance. Simply put, the second question presented is not of the kind con-

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[4] In fact, Connecticut General introduced ample evidence to support its position that the plan in question was an ERISA plan and that the petitioners' claims were therefore preempted. *See, infra*, Part III, A.

templated for review by Rule 17 of the Rules of this Court.

III

The Ninth Circuit Correctly Concluded That ERISA Preempts the Petitioners' Claims

The Ninth Circuit concluded both that the plan in question was governed by ERISA and that ERISA preempts petitioners' claims for improper processing under Section 790.03. In addition to the reasons already discussed, a third reason for denying the Petition is that the Ninth Circuit decided these questions correctly.

A. The Record Presented Supports the Rulings Below With Respect to the Existence of an ERISA Plan

Theodore Kanne was employed by Harlow Carpets, a member of an employer group called The Associated Builders and Contractors ("ABC"). 867 F.2d, at 491, Pet. app. at D-85. ABC administered a group health insurance plan to which Harlow Carpets subscribed. *Id.* As required by ERISA, ABC established the plan as a trust entity called the ABC Trust. *Id.* The trust purchased a group health insurance policy from Connecticut General. *Id.* The plan brochure described the plan as an ERISA plan. *Id.* As an employee of Harlow Carpets, Mr. Kanne was covered by the policy. *Id.* ERISA provides in pertinent part:

> The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5). Under this provision, the Ninth Circuit concluded that, because it administered the plan on behalf of Harlow Carpets and its other members, "ABC can be an ERISA employer for purposes of our analysis." 867 F.2d, at 493, Pet. app. at D-90.

Petitioners challenge this conclusion on the ground that "there was no evidence that Harlow Carpets (or, for that matter, any other employer) played any part in the management of ABC, the purported 'ERISA employer,' and no evidence that ABC was a group of homogeneous, related employers." Pet. at 49-50. As noted above, petitioners failed to dispute the existence of an ERISA plan at trial or even on appeal except on rehearing, so that it is understandable that Connecticut General had no opportunity to respond with evidence to these tardy objections by petitioners. Nevertheless, based on the evidence in the record before it, the district court specifically concluded that "the plan under scrutiny is an ERISA plan." 607 F. Supp., at 904. When petitioners finally objected to this conclusion in their petition for rehearing and the Ninth Circuit agreed to review the question, that court was certainly entitled to base its decision on, and to draw reasonable inferences from, the record before it.

That record amply supports the conclusion that Harlow Carpets was a member of ABC, that ABC was an employer association of builders and contractors, that ABC established and administered an ERISA medical benefits plan for its member firms, and that Harlow Carpets subscribed to the plan. Given the lack of any contrary evidence, the court of appeals was more than justified in concluding, in the words

of ERISA, that ABC was "a group or association of employers acting for" Harlow Carpets "in relation to an employee benefit plan." 29 U.S.C. § 1002(5).

Having correctly found ABC to be an "employer" within the meaning of ERISA, the court below analyzed whether the plan in question was governed by ERISA. In doing so, that court examined regulations promulgated by the Secretary of Labor defining the phrase "employee welfare benefit plan." Those regulations bring within ERISA's coverage all group insurance programs except those that possess four specified attributes. *See* 29 C.F.R. § 2510.3-1(j)(1987).

The regulation provides in relevant part that an ERISA plan

> shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; *and*
>
> (4) The employer or employee organization receives no consideration in the form of cash

> or otherwise in connection with the program, other than reasonable compensation, excluding any profit, or administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j) (1987) (emphasis added).

Petitioners argued that the ABC plan fell within all four of these criteria and was therefore excluded from ERISA's coverage. The Ninth Circuit disagreed, noting that the failure to possess of any one of the four criteria "would prevent the exclusion of the insurance plan from ERISA coverage." 867 F.2d, at 492. Although that court found the record less than comprehensive regarding the first, second, and fourth criteria, it found that the plan clearly failed to satisfy the third criterion and therefore was not excluded from ERISA coverage. *See* 867 F.2d, at 492-93.

Petitioners do not seriously dispute the Ninth Circuit's conclusion under the regulation. Rather, they question the validity of the regulation itself. *See* Pet. at 45-47.[5] Petitioners cite two cases they say have

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[5] Petitioners raised no such challenge to the regulation before the Ninth Circuit, thus depriving the Labor Department of any opportunity to defend its approach in the court below. Petitioners not only failed to challenge the regulation below, but actually themselves relied on it in support of their claim. Thus, in their petition for rehearing in the Ninth Circuit, petitioners cited a case which, according to petitioners, "points out that under 29 C.F.R. Section 2510.3-2(i) *ERISA does not apply to insurance arrangements in which the employer is virtually uninvolved, i.e., makes no contributions.*" Brief for Rehearing of Plaintiffs and Appellees at 11-12, *Kanne* v. *Connecticut General Life Insurance Co.*, 819 F.2d 204 (9th Cir. 1987) (No. 85-5641) (emphasis in original). Having relied on the regulation below, petitioners should not now be permitted to challenge it in this Court.

rejected the approach adopted in the Labor Department's regulations. Both of these cases are from the California Court of Appeal. The first, *Rizzi* v. *Blue Cross of Southern California*, 206 Cal. App. 3d 380 (1988), held that an employer's purchase of a group medical insurance policy for its employees and payment of the premiums established an ERISA plan, even though the employer performed no administrative functions with respect to the plan. In addition, the court held that ERISA preempts both common law and Section 790.03 claims relating to unfair claims practices. The court expressly agreed with the Ninth Circuit in *Kanne* that *Pilot Life* requires such preemption. Thus, *Rizzi* actually undercuts rather than supports petitioners' position.

The second case cited by petitioners, *Sayble* v. *Blue Cross of Southern California*, 208 Cal. App. 3d 1108 (1989), held that an ERISA plan had not been created where the employer did not participate in the administration of the insurance benefit. *Id.*, at 1117. Although that case appears, at least superficially, to support petitioners' position, it is not a decision of a "state court of last resort," so that its departure from *Kanne* does not present a conflict within the purview of Rule 17 of the Rules of this Court. To the contrary, the California Supreme Court's only decision in this area is *Commercial Life Insurance Co. v. Superior Court*, 47 Cal. 3d 473, 764 P.2d 1059 (1988), *cert. denied sub nom. Juliano* v. *Commercial Life Insurance Co.*, 57 U.S.L.W. 3753 (U.S. May 15, 1989). Although *Commercial Life* did not have occasion to address the applicability of the pertinent regulations, the opinion specifically endorsed and relied on the Ninth Circuit's decision in *Kanne*.

Apart from citing these cases, petitioners give no explanation why the Secretary of Labor's interpretation of ERISA's coverage is not entitled to deference in this case. As this Court observed just this Term in support of a particular interpretation of ERISA: "The Secretary, who is specifically authorized to define ERISA's 'accounting, technical, and trade terms,' and to whose reasonable views we give deference, has also so understood the statute." *Massachusetts v. Morash*, 109 S. Ct. 1668, 1673-74 (1989) (footnote and citations omitted). Thus, the Secretary's view of ERISA's coverage is entitled to substantial weight, and the Ninth Circuit was entirely correct in following it in this case.

B. The Ninth Circuit Correctly Concluded That ERISA Preempts Petitioners' Section 790.03 Claim

The Ninth Circuit also decided that ERISA preempts the petitioners' Section 790.03 claim. Petitioners contend that this conclusion is inconsistent with this Court's decision in *Pilot Life* and with ERISA's savings clause. Neither contention is tenable.

The court of appeals in *Kanne*, and the California Supreme Court in *Commercial Life*, *supra*, found private causes of action under California's Section 790.03 to be preempted under the approach adopted by this Court in *Pilot Life*. In *Pilot Life*, the Court concluded that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." 481 U.S., at 52; *see id.*, at 54. Moreover,

this Court found a "clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive." *Id.*, at 57. In this case, the Ninth Circuit did "not find it possible to read [*Pilot Life*] in a way that permits a state statute like § 790.03(h) to supplement the ERISA civil enforcement provisions available to remedy improper claims processing," 867 F.2d, at 494, and thus found petitioners' Section 790.03 claim to be preempted. *Id.*

Petitioners claim that the court of appeals reading of *Pilot Life* conflicts with the language of the savings clause because Section 790.03 is a law "which regulates insurance." *See* Pet. at 28. However, the Ninth Circuit found that even if Section 790.03 was enacted to regulate insurance, the implied right of action formerly recognized in California was nonetheless preempted under this Court's interpretive approach in *Pilot Life*.[6] In *Pilot Life*, the Court divined ERISA's preemptive force by reference to the language, structure, and legislative history of its civil enforcement provisions. *See* 481 U.S., at 52. *Pilot Life* concluded that ERISA's civil enforcement provisions were intended to provide the exclusive remedies for ERISA-plan participants claiming improper processing of claims. Petitioners' position is that the savings clause should be read to preserve state law causes of action

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[6] As the court stated:

> We can assume, without deciding, that § 790.03(h) is a law regulating insurance under the savings clause. Nevertheless, under *Pilot Life* we find the conclusion inescapable that the private right of action for violation of § 790.03(h) is preempted by ERISA.

867 F.2d, at 493 (footnote omitted).

even though they intrude on the exclusive federal remedies established by ERISA. But *Pilot Life* establishes that the savings clause must be interpreted in light of ERISA's exclusive civil enforcement mechanisms, and that, as so interpreted, the savings clause does not save from preemption causes of action such as those that were (but no longer are) implied from Section 790.03.

An additional flaw in petitioners' argument is that it fails adequately to distinguish between a law regulating insurance and implied rights of action that provide supplemental means of enforcement. Neither *Pilot Life* nor the court of appeals' opinion in this case suggests that ERISA preempts Section 790.03 itself. Rather, these cases stand for the more limited proposition that certain means of enforcement—in this case, an implied private right of action by the ERISA-plan participant—are inconsistent with ERISA's exclusive civil enforcement mechanisms for private claims and therefore are preempted. Enforcement of Section 790.03 through administrative proceedings, unlike an implied private cause of action, would not appear to conflict with ERISA's exclusive civil enforcement remedies established for use by ERISA-plan participants. This is so because implied private causes of action like the one in this case are brought by the ERISA-plan participant whereas administrative and regulatory proceedings are conducted by the state insurance commissioner. Only the former means of enforcement were considered by the Ninth Circuit in this case.[7]

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[7] Indeed, in finding petitioners' Section 790.03 cause of action to be preempted, the court of appeals expressly noted: "We

CONCLUSION

The petition for writ of certiorari in this case presents one question that is of ephemeral interest in a limited number of California cases and that already has been resolved consistently by the Ninth Circuit and the California Supreme Court. The second question is of equally limited significance because it was resolved against petitioners by both courts below based upon the particular facts of this case, facts that petitioners failed to contest in a timely fashion. For these reasons, the Petition should be denied.

Respectfully submitted,

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June 1, 1989

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express no opinion as to whether the *substantive* provisions of § 790.03(h) are themselves preempted so as to bar administrative enforcement by California's Insurance Commissioner." 867 F.2d, at 493 n.6 (emphasis added), Pet. app. at D-94.

Supreme Court, U.S.
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No. 88-1659

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

REPLY BRIEF OF PETITIONERS

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No. 88-1659

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL LIFE
INSURANCE COMPANY,

Respondent.

REPLY BRIEF OF PETITIONERS

In its Brief in Opposition to Petitioners' Petition for Writ of Certiorari, respondent does not deny that throughout these proceedings, respondent and its prior counsel took the position that the questions presented by the Kannes' petition were of great national importance, meriting the Amicus Curiae

intervention of the United States Government, among others. See, e.g., Petition at pp. 23, 25, FN 14, 53. [1] Respondent now attempts to ignore its previous statements, arguing that the first question is not really that important (RB at pp. 3-7). We respectfully disagree with that contention (Point I, infra).

Respondent does not seriously deny that the second question--the issue of the criteria necessary to establish that a group insurance arrangement is an employee benefit plan subject to ERISA (see Petition, pp. i-iv, Questions 2a and 2b)--is of critical national importance. Respondent therefore attempts to evade

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1. References herein to "Petition" refer to the Kannes' Petition for a Writ of Certiorari, docketed April 11, 1989. References to "RB" refer to Respondent's Brief in Opposition, dated June 1, 1989.

the issue, by claiming, among other things, that the second question was not properly presented because, respondent says, the Kannes never disputed the existence of an employee benefit plan subject to ERISA (RB at pp. 7-10).

This claim is simply untrue. The Kannes disputed the existence of an ERISA plan in the District Court, in their original responsive brief on the appeal to the Ninth Circuit Court of Appeals, and in all other briefs they have filed in this case (Point II, infra). [2]

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2. Respondent cites no reference for its claim that the issue was not properly raised or preserved. It refers to a statement in the Kannes' Petition that the issue of ABC Trust's status as an "ERISA employer" was never contested (e.g., RB at p. 9). However, this issue was not contested because respondent never claimed that ABC Trust was an "ERISA employer," and only claimed that the involvement of Mr. Kanne's direct employer established an ERISA plan (see Point II, infra).

Respondent's present attempt to sidestep this issue with this contention, and the others it presents, demonstrates that respondent does not, and cannot, deny that this issue must be resolved by this Court in light of the literally millions of employees throughout this country who are utterly dependent on employee group insurance to cover them when catastrophe strikes. We respectfully submit that this Court should resolve this issue now, rather than permit the confusion and uncertainty to proliferate, causing grave detriment to the economical and efficient administration of justice in the federal courts, as well as the courts of all 50

states. [3]

I

THE ISSUE OF WHETHER STATE REMEDIES MAY BE APPLIED TO STATE LAWS REGULATING INSURANCE IS A WIDESPREAD AND IMPORTANT NATIONAL ISSUE.

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3. Under the situation now prevailing, every suit for delay or denial of benefits in an employee group insurance policy will be subject to threshold litigation on the issue of whether such a policy is an employee benefit plan governed by ERISA. Without guidance from this Court, the federal and state courts will continue to apply conflicting and amorphous standards in their struggle to resolve this issue.

Indeed, respondent recognizes the inconsistencies that have already arisen on this subject, in its discussion of two California Court of Appeal cases. Respondent attempts to dismiss them because they are not decisions of courts of last resort (RB at p. 14). The point is, however, that numerous lower courts, both state and federal, will be wrestling with this issue, all of necessity relying on authorities that are conflicting and not determinative. The California cases, as well as numerous others, illustrate the mushrooming nature of the issue.

Respondent relies on the prospective abolition of the private right of action in California as a basis for its claim that the first question presented by the Kannes' Petition is not important (RB at pp. 3-7). We respectfully submit this argument is without merit. There is no question that the States have an overriding interest in protecting their citizens from unfair insurance practices, which all too often have the effect of placing the ill and disabled in positions of dependency on State assistance programs. As pointed out in our Petition, the California Supreme Court has specifically stated that the Legislature has the power to reinstate the right of action prospectively abolished by the Court's decision in Moradi-Shalal v. Fireman's Fund Ins. Co., 46 Cal. 3d 287, 758 P.2d 58 (1988)

(Petition at pp. 25-26). Other states similarly have enacted laws aimed at deterring unfair insurance practices or may wish to consider doing so. We respectfully submit that this Court should issue a clear, definitive pronouncement on the issue of whether ERISA blocks enforcement of such laws where ERISA plans are involved.

Moreover, respondent has not explained how the Court of Appeals' interpretation of this Court's decision in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549 (1987) can be reconciled with the plain words of the relevant statute, which exempts State laws regulating insurance from the enforcement provisions of ERISA (see

Petition at pp. 28-29). [4] Nor does respondent deny our statement that nothing in the legislative history of ERISA shows that Congress intended to interpret the saving clause in the manner in which the Ninth Circuit has interpreted it in this case. We respectfully submit that it is clear that an erroneous interpretation of an act of Congress of such widespread impact is in itself sufficient to merit consideration by this Court, and particularly when the subject affects literally millions of employees throughout the country.

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4. Respondent does not deny that California Insurance Code section 790.03(h) is a State law regulating insurance.

II

RESPONDENT IS INCORRECT IN ITS STATEMENT THAT PETITIONERS DID NOT PROPERLY RAISE OR PRESERVE THE ISSUE OF WHETHER OR NOT RESPONDENT'S INSURANCE POLICY CONSTITUTED AN ERISA PLAN.

As observed above, there is no merit to respondent's claim that petitioners did not properly raise or preserve the issue of whether the insurance policy constitutes an employee benefit plan governed by ERISA (RB at pp. 7-10). Respondent raised the issue in the District Court and the District Court found that the insurance arrangement was an ERISA plan (Appendix to Petition, p. A-12). On appeal, the Kannes' responsive brief, dated and served January 13, 1986, specifically contested respondent's contention that there was an ERISA plan,

citing Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 (5th Cir. 1980), cert den. sub. nom., Taggart Corp. v. Efros, 450 U.S. 1030, 101 S.Ct. 1739 (1981) and Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (Appellee's Responsive Brief at pp. 6-8).

This issue was also consistently raised thereafter by the Kannes in the Court of Appeals in their Supplemental Brief and in their two Petitions for Rehearing. Never, at any time until now, did respondent ever claim the issue was not properly raised.

However, the issue presented by respondent and litigated in the District Court was the claim that Mr. Kanne's actual employer, Harlow Carpets, had established or maintained an employee benefit plan subject to ERISA. Respondent did not raise or litigate any

claim that the ABC Trust was an employer group within the meaning of 29 U.S.C. section 1002(5), and that issue was never litigated (see Petition at p. 20, Appendix D to Petition at p. 86). The Court of Appeals thus made two rulings: (1) it rejected the claim that respondent actually litigated--respondent's claim that Mr. Kanne's direct employer had established or maintained an ERISA plan and (2) on its own motion, it decided an issue that was not litigated--that ABC Trust's activity as an employer group supported the finding that an ERISA plan was involved. [5]

Obviously, the fact that respondent did not litigate this latter claim does

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5. As we pointed out in our Petition for Rehearing to the Court of Appeals, filed October 17, 1988, respondent did not even claim on appeal that ABC Trust was an "ERISA employer" (Petition for Rehearing at p. 12).

not inure to respondent's benefit, since respondent had the burden of proving that federal law is applicable. Metropolitan Life Ins. Co. v. Taylor, 107 S.Ct. 1542, 1546 (1987).

Respondent does not now claim, and never attempted to prove, that individual employers played any part in the management of ABC, or that ABC consisted of homogeneous related employers, as required in order for it to be an "ERISA employer" (see Petition at pp. 47-49). Respondent's Opposition does not deny that these elements are necessary, and does not claim that they were proven (RB at pp. 10-11). Respondent claims only that "petitioners failed to dispute the existence of an ERISA plan at trial or even on appeal except on rehearing, so that it is understandable that Connecticut General had no opportunity to

respond with evidence to these tardy objections by petitioners." (id at p. 11). This statement is incorrect. As shown above, petitioners did dispute the existence of an ERISA plan at trial and on appeal. Moreover, since it was incumbent on respondent to establish that an ERISA plan existed, respondent had the burden of adducing this evidence. Respondent did not do so and, indeed, as indicated above, respondent never even attempted on appeal to claim that ABC was an "ERISA employer" (see FN 5, supra).

Respondent interprets our Petition as an attempt to urge that the criteria of the Department of Labor regulations are incorrect (RB at pp. 12-15). Respondent misapprehends the point. The question of whether the Department of Labor regulations are the determinative criteria is the subject of a conflict

among the decisions (see Petition at pp. 45-47), and is a question which requires resolution by this Court.

Respondent also attempts to avoid review of this urgent issue by characterizing it as a "highly fact-specific question" (e.g., RB at p. 7). We respectfully submit that it is not a "fact-specific question," but a question of law concerning what criteria or elements will satisfy the statutory definition of an employee benefit plan. At this juncture, the bench and bar do not have an answer to this question to apply to the literally thousands of cases that will inevitably arise that require resolution of this question. We therefore respectfully submit that it is urgent that this Court furnish this answer.

Conclusion

The Kannes' Petition should be granted.

Respectfully submitted,

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OCTOBER TERM, 1988

THEODORE KANNE and BEATRIZ KANNE,
Petitioners,

vs.

CONNECTICUT GENERAL LIFE INS. CO.,
Respondent.

BRIEF FOR CALIFORNIA TRIAL LAWYERS ASSOCIATION AS AMICUS CURIAE SUPPORTING PETITIONERS

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BRIEF FOR
CALIFORNIA TRIAL LAWYERS ASSOCIATION
AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF AMICUS CURIAE

The California Trial Lawyers Association ("CTLA"), founded in 1962, is a voluntary organization composed of approximately 5,000 trial lawyers who appear regularly in state and federal courts. The predominant practice of most CTLA members is the representation of injured tort victims and victims of consumer fraud.

CTLA is concerned that the Court of Appeal's interpretation of ERISA to preempt state statutory laws which expressly regulate the business of insurance and the standard which is applied to define the existence of an ERISA plan will undermine the states' ability to regulate insurance industry abuses with no corresponding federal remedy to replace it. The definitive

historical relationship between the McCarran-Ferguson Act, the Model Trade Practices Act, and the "saving" clause of ERISA, was not seriously discussed in the briefing below, nor in the opinion of the Court of Appeal below. CTLA believes that this brief will fill a much needed "gap" in the presentation to this Court as to this vital issue. Letters from counsel for Petitioner and Respondent, consenting to the filing of the brief, are filed concurrently with the Court.

PRELIMINARY STATEMENT

For the entire history of our federal nation, with the single exception of one-and-a-half years, the business of insurance has been subject to the nonuniform regulations of the various states. In 1944, however, in United States v. Southeastern

Underwriters Assn., 322 U.S. 533, 64 S.Ct. 1106, 88 L.Ed. 1440 (as will be discussed in greater detail herein), this Court abruptly reversed 75 years of contrary precedent and held that insurers were subject to federal regulation. In his dissenting opinion, Chief Justice Stone warned against "the wide ramifications of establish[ing] a new boundary between state and national power . . . ." In a separate dissent, Justice Robert Jackson argued that it was improper to nationalize insurance regulation by court decision and maintained that the long held doctrine of state regulation of insurance should be overturned by Congress and not by the courts. As discussed hereinafter, Congress reacted by passing the McCarran-Ferguson Act in 1946 to ensure that federal law does not supersede state insurance laws.

The moral of the story, for present purposes, is plain—if laws which "regulate insurance," such as the Unfair Claims Practices Act, are to be nationalized, it is for Congress to do so. To date, it has repeatedly expressed a steadfast desire not to do so.

As will be demonstrated herein, the McCarran-Ferguson Act was indeed the prototype of a state law regulating the business of insurance and served as the inspiration for the "saving" clause of ERISA.

REASONS FOR GRANTING THE PETITION

A. WHEN CONGRESS DOES NOT EXPLICITLY STATE ITS INTENT REGARDING PREEMPTION, THE COURTS SHALL DECLARE PREEMPTED STATE LAWS WHICH IMPINGE ON FEDERAL REMEDIES; THIS RULE HAS NO APPLICATION, HOWEVER, WHERE CONGRESS HAS EXPLICITLY DECLARED ITS INTENT.

The argument that the courts should infer Congressional intent to preempt state

laws which, although they regulate insurance, impinge on ERISA remedies, would make sense if Congress had not explicitly stated its intent with respect to preemption.

In Allis-Chalmers Corp. v. Lueck (1985) 471 U.S. 202, 105 S.Ct. 1904, 85 L.Ed.2d 206, the Court was faced with the task of determining the preemptive effect of the Labor Management Relations Act (LMRA) with respect to a state bad faith tort claim. This task was made difficult by the failure of Congress to express its intent with respect to preemption. Thus, the Court was compelled to engage in the following analytical process (at 471 U.S. 208):

> "Congress did not state explicitly whether and to what extent it intended § 301 of the LMRA to preempt state law. In such instances courts sustain a local regulation 'unless it conflicts with federal law or would frustrate the federal scheme, or unless the courts discern from the totality of the circumstances that Congress sought to occupy the field to the exclusion

of the States.' Malone v. White Motor Corp."

As the Court did not have the luxury of merely enforcing the expressed intent of Congress, it necessarily employed this "secondary" analysis in order to infer legislative intent. Here, Congress has not left its intent unarticulated. If it had failed to address the issue in ERISA, then the Court would properly be charged with determining if "a local regulation conflicts with federal law or would frustrate the federal scheme, ..." etc. However, unlike the LMRA, "Congress did . . . state explicitly whether and to what extent it intended [ERISA] to preempt state law." The Court's task is, thus, much easier, i.e., to simply follow the Congressional intent, explicitly stated. If a state law "regulates insurance" (albeit the determination of which may be difficult under

the two-tiered, three-prong test of Pilot Life Insurance Company v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549), it is not preempted--so says Congress explicitly. The state insurance law may conceivably "conflict with federal law" and, absent a legislative declaration to the contrary, would be construed to be preempted by the courts, but it is nevertheless "saved" from ERISA preemption because Congress has said so. To simply ignore this express statement of intent and to employ the Allis-Chalmers "inferential intent" approach (which applies when "Congress did not state explicitly whether and to what extent it intended [legislation] to preempt state law"), makes no rational sense and does violence to the intent of Congress. Congress knew that its silence could be construed to preempt state insurance laws

under Allis-Chalmers. It chose not to remain mute. Instead, it chose to explicitly reconfirm the power of the states to regulate insurance. This goal was, apparently, more important to Congress than achieving absolute uniformity under ERISA. Wise or foolish, it was a decision properly made by the legislature and should be properly respected by the courts.

Amicus will now demonstrate that the Unfair Claims Practices Act (California Insurance Code section 790.03(h)) is a law which "regulates insurance" within the meaning of the saving clause as determined by the test of Pilot Life. The mandatory language of the saving clause thus dictates a singular result, i.e., saving from preemption.

B. THE McCARRAN-FERGUSON ACT, THE ANALYTICAL BELLWETHER OF PILOT LIFE WITH RESPECT TO WHETHER A STATE LAW "REGULATES INSURANCE" FOR THE PURPOSE OF THE ERISA SAVING CLAUSE, WAS SPECIFICALLY DESIGNED TO SAVE FROM FEDERAL PREEMPTION THE "MODEL TRADE PRACTICES" ACT UPON WHICH CALIFORNIA INSURANCE CODE SECTION 790.03 IS BASED.

1. A "Common Sense View Of The Language."

This Court, in Pilot Life Insurance Company v. Dedeaux, supra, formulated a two-part test to determine whether any particular state law "regulates insurance" within the meaning of the "saving" clause of ERISA (29 U.S.C. § 1144(b)(2)(A)) and is thereby saved from preemption under 29 U.S.C. § 1144(a). The first prong--a "common sense view of the language of the saving clause itself" (471 U.S. at 740)--is clearly satisfied in the case of the California Unfair Claims Practices Act in that the express purpose of the act is "to regu-

late trade practices in the business of insurance" (§ 790) and § 790.01 limits application of the Act to "persons engaged in the business of insurance." Thus, § 790 is "specifically directed toward that industry" as is required under Pilot Life (471 U.S. at 740) in order to come within the saving clause. See Dill v. Claims Administration Services, Inc. (1986) 178 Cal.App.3d 1184.

2. The McCarran-Ferguson "Business Of Insurance" Factors.

This second tier of analysis requires a review of the history and the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 et seq. The second prong is, in turn, trifurcated into the three subissues: (1) risk spreading, (2) integral part of the relationship, and (3) limited to the insurance industry.

In putting § 790.03 to the test of the three McCarran-Ferguson criteria for determining the "business of insurance," the saving clause of ERISA comes into unique historical focus with the very state law which is being measured, i.e., the Unfair Claims Practices Act. Understanding why the Pilot Life Court required such an analysis is crucial to appreciating the identity of purpose between the saving clause of ERISA and the McCarran-Ferguson Act. In a nutshell, both statutes were specifically crafted by Congress to prevent federal preemption of state laws which regulate the business of insurance. As will be discussed hereinbelow, the Model Trade Practices Law, upon which § 790.03 was based, was a specific reaction to, and an intended result of, the passage of the McCarran-Ferguson Act. Therefore, § 790.03

is virtually "per se" a law enacted for the "purpose of regulating the business of insurance" under the McCarran-Ferguson Act and is thus saved from ERISA preemption under Pilot Life as a law which "regulates insurance."

3. The History Of Federal Preemption Of State Insurance Laws Leading To The Salutary Provisions Of The McCarran-Ferguson Act.

Originating with Paul v. Virginia, 8 Wall. 168, 19 L.Ed. 357 (1869), it was assumed that insurance was not a "transaction of commerce" and was thus exempt from federal regulation under the Commerce Clause in general and from federal antitrust statutes in particular. Then, in 1944, in United States v. Southeastern Underwriters Assoc., 322 U.S. 533, 64 S.Ct. 1162, 88 L.Ed. 1440, the Court abruptly reversed itself and held that the insurance industry was subject to the Commerce Clause

and federal regulation, including antitrust laws. Deeply concerned about the inroads the court's decision might make on the tradition of state regulation of insurance, Congress reacted quickly and decisively by passing the McCarran-Ferguson Act of 1945. The stated purpose of the Act is set forth at 15 U.S.C. § 1011:

> "Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." (Emphasis added.)

The Act itself is set forth at 15 U.S.C. § 1012:

> "(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." (Emphasis added.)
>
> "(b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any

> State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance; provided, that after June 30, 1948, the Act of July 2, 1980, as amended, known as the Sherman Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law." (Emphasis added.)

4. This Court Recognizes The Identity Of Purpose Between The McCarran-Ferguson Act And The ERISA Saving Clause.

In Prudential Insurance Company v. Benjamin, 328 U.S. 408, 66 S.Ct. 1142, 90 L.Ed. 1342 (1946), the Court commented as follows:

> "Obviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."

In nearly identical fashion, Congress drafted the saving clause in ERISA so that "nothing in this subchapter shall

be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ." 29 U.S.C. § 1144(b)(2)(A).

Under the McCarran-Ferguson Act, there is no generalized federal preemption because, although insurance is now subject to the commerce clause and the possibility of federal regulation, the business of insurance is still subject to state laws which regulate the business of insurance and no federal law will be construed to preempt any state law which "regulates the business of insurance" unless the federal law specifically relates to the business of insurance. Thus, in one sense, the saving clause of ERISA does no more than what the McCarran-Ferguson Act requires in any event; that is, since ERISA itself does not "specifically relate to the business

of insurance," it may not be construed to preempt state laws which regulate the business of insurance.

This Court gave explicit recognition to the identity of purpose between the ERISA saving clause and the McCarran-Ferguson Act in Metropolitan Life Ins. Co. v. Massachusetts (1985) 471 U.S. 724, 105 S.Ct. 2380, which was cited with approval and relied on in Pilot Life. After quoting from the McCarran-Ferguson Act, the court stated as follows: "The ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language

to define what is left to the States." (Emphasis added.) Moreover, ERISA specifically provides that none of its provisions shall be construed to supersede any pre-existing federal statute. 29 U.S.C. § 1144(d). The McCarran-Ferguson Act is such a pre-existing federal statute. (See Metropolitan Life Insurance Co. v. Massachusetts, supra.) This reasoning process was again recognized and applied by the Court in Pilot Life, supra.

5. The Circumstances Under Which The McCarran-Ferguson Act Was Passed, And The State Legislative Response Thereto, Definitively Demonstrate Congressional Intent Not To Preempt The Model Trade Practices Act Upon Which Section 790.03(h) Is Based.

Most significant to a determination of the present issue (i.e., whether Insurance Code § 790.03 is a law regulating insurance and thus saved from ERISA preemption) is the historical response to the "proviso" of subsection (b) of the Act.

The states were given three years to pass laws which "regulate the business of insurance" in order to avoid preemption by the federal antitrust and Federal Trade Commission laws. In response, the states flurried to pass a series of laws regulating the business of insurance pursuant to the McCarran-Ferguson Act. One of the foremost efforts was the adoption by the National Association of Insurance Commissioners (NAIC)--the very organization which sponsored the McCarran-Ferguson Act[1]--of the Model Trade Practices Act from which the Model Unfair Claims Practices Act was

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[1]See House Report No. 143 (February 13, 1945), U.S. Congressional Service, 79th Cong., 1st Sess. "The views of the NAIC are particularly significant because the Act ultimately passed was based in large part on the NAIC bill." Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. at 221, 99 S.Ct. at 1078.

derived.[2] California adopted the Model Trade Practices Act and Model Unfair Claims Practices Act by enacting Insurance Code §§ 790, et seq. (See NAIC Model Regulation Service — July 1986, showing that all 50 states had adopted the model or similar legislation.)[3]

In dramatic fashion, § 790 expressly states—using the language of the Model Act—that it was enacted as a law to regulate the business of insurance under the McCarran-Ferguson Act: "The purpose

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[2]See 12 William Mitchell Law Review at 49-51 (1985).

[3]"To avoid the loss of state regulatory authority to the Federal Trade Commission, state regulators and the insurance industry jointly sponsored legislation preserving the powers of the state commissioners to regulate the business of insurance. The National Association of Insurance Commissioners (NAIC) developed the Model Fair Trade Practices Law for that purpose, which was quickly adopted by the majority of states." 12 Wm. Mitchell L.Rev. at 50 (1985).

of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Cong.) [i.e., the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." (Emphasis added.)

Could there ever be a more explicit example of a state law which regulates the "business of insurance" under the McCarran-Ferguson Act and, thereby, must be considered a "law regulating insurance" and saved from ERISA preemption under Pilot life? Unlike the common law tort of bad faith in Mississippi which can arise out of a breach

of contract and which, under Pilot Life, is not a law which regulates insurance under the McCarran-Ferguson Act, California Insurance Code §§ 790 et seq. were specifically and expressly enacted as a law regulating insurance under the McCarran-Ferguson Act.

6. Congressional Intent To Save State Laws Regulating Insurance From Preemption By ERISA Was Reaffirmed By Congress After Enactment Of ERISA When Congress Amended The Federal Trade Commission Act In 1980.

The Congressional approval of free and unfettered state regulation of insurance was reaffirmed unequivocally when Congress in 1980 amended the Federal Trade Commission Act. (15 U.S.C. § 46, subd. (h), hereinafter FTC Act 1980 Amendment.) This amendment, made after the passage of ERISA, is of great importance in deciding the preemptive scope of ERISA for three distinct reasons:

First, the conference report on the FTC Act 1980 Amendment stated as follows: "[T]he conferees wish to indicate their strong reaffirmation of the basic policy of the McCarran-Ferguson Act: That the business of insurance is to be regulated by the States." (House Conf. Rpt., 1980 U.S.C. Cong. & Adm. News 1144; see also explanation of report in the Senate, 126 Cong. Rec. 11916, col. 1.)

Second, the legislative history of the FTC Act 1980 Amendment reveals not only that Congress desires unimpeded state regulation of insurance, but that Congress also considers the Unfair Practices Acts to be important vehicles for state control over the business of insurance. (See, e.g., comments of Sen. Durkin, 126 Cong. Rec. 2369.) Senator Metzenbaum expressed concern that all states had not adopted laws

which included "systematic procedures to determine whether insurance consumers are being rated properly with respect to such matters as claims payment . . . ." but nonetheless felt that the states should retain control over insurance regulation. (126 Cong. Rec. 2374.) Senator Durkin concluded that there is "the potential for being a much stronger regulatory system when you have 54 commissioners trying different ways to improve regulations . . . ." than when the federal government steps in. (126 Cong. Rec. 2376.) These comments confirm Justice Rehnquist's conclusion in Union Labor Life Ins. Co. v. Pireno, 102 S.Ct. 3002, 458 U.S. 117 at 136-138 (1982), that claims adjustment is at the heart of the business of insurance, and that it is a matter to be regulated by the states.

Third, and most important, the Congressional stand on state supremacy in insurance regulation manifested in the legislative history of the FTC Act 1980 Amendment amplifies the conclusion that Congress does not intend for ERISA (nor any other of its enactments) to be construed or interpreted in any way that disrupts state regulation of the business of insurance assured by the McCarran-Ferguson Act.

C. ANY NONUNIFORMITY IN REMEDIES AVAILABLE TO INSUREDS UNDER ERISA PLANS THROUGHOUT THE FIFTY STATES IS A FUNCTION OF THE EXISTENCE OF THE SAVING CLAUSE—NOT ITS INTERPRETATION; PERFECT UNIFORMITY CAN BE ACHIEVED ONLY BY REWRITING THE SAVING CLAUSE.

The additional concern of the Court in Pilot Life for "the role of the saving clause in ERISA as a whole" and "remedies under state law that Congress rejected in ERISA," when applied to state bad faith tort laws of general application, must be

reconciled with its conclusion two years earlier in Metropolitan Life Ins. Co. v. Massachusetts, supra, as applied to a state statutory regulation applicable only to the insurance industry. In Metropolitan Life, the Court stated as follows:

> "[W]hile the general preemption clause broadly preempts state laws, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulations." (Emphasis added.)
>
> * * *
>
> "We must also presume that Congress did not intend to preempt areas of traditional state regulation." (Emphasis added.)
>
> * * *
>
> "The presumption is against preemption and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope."
>
> * * *
>
> "We therefore decline to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modified it. If a state law 'regulates insurance,' it is not preempted. Nothing in the language, structure,

> or legislative history of the Act supports a more narrow reading of the clause, whether it be the Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA, or the insurer's more speculative attempt to read the saving clause out of the statute." (Emphasis added.)

* * *

The insurance industries' argument that § 790.03 should be preempted because, otherwise, insured and self-funded plans would be subjected to potentially disparate regulation, has already been rejected by the Court. In Metropolitan Life Ins. Co. v. Massachusetts, supra, the Court stated as follows:

> "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter. We also are aware that appellant's construction of the statute would

> eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, address the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress." (Emphasis added.)

In Metropolitan Life Ins. Co. v. Massachusetts, supra, 471 U.S. at 746, the Court specifically rejected a "conflict" interpretation of the "saving" clause, i.e., that only state laws which did not directly conflict with the substantive provisions of ERISA were saved from preemption. The Court, instead, held that the "saving" clause of ERISA meant precisely what it says, i.e., that a state law regulating insurance is simply not preempted. Thus, the contention that the remedial provisions of ERISA have some sort of uncodified and unexpressed preemptive effect independent

of the "saving" clause, is meritless. Moreover, any such construction of ERISA would be contrary to 29 U.S.C. § 1144(d) which precludes interpretation of ERISA as to supersede any pre-existing federal legislation including McCarran-Ferguson which precludes federal preemption of state laws regulating insurance.

It was Congress' desire to provide for uniformity of laws applicable to employee benefit plans—not insurers. Employee benefit plans are not engaged in the business of insurance, even when they are self-funded and look and act like insurers. Analogously, insurance policies and the insurers that issue the policies are not employee benefit plans. (HCR. Rep. No. 1785, 94th Cong. 2d Sess. 48 (1976).)

The legislative history of the McCarran-Ferguson Act, amplified and reaffirmed

in the legislative history of the FTC Act 1980 Amendment, as well as in the Metropolitan Life decision, reveals that Congress fully endorses disuniformity in the various states' separate systems of the regulation of the business of insurance, and that the McCarran-Ferguson Act was passed to preserve the states' right to pass varying laws regulating the business of insurance. "Every state in this Union built up a code of laws and established a commission or committee of some kind to handle insurance in accordance with what they thought were the needs of their particular state." (90 Cong. Rec. 6535.) "If the states are to be permitted to regulate, each of them should be permitted to regulate as it sees fit." (90 Cong. Rec. 6536; see, e.g., 90 Cong. Rec. 6550, 6554; 126 Cong. Rec. 2376, 11915.)

This Court, on more than one occasion, has recognized that Congress accepts the disuniformity of laws regulating insurance which naturally flows from the McCarran-Ferguson Act. "Moreover, in taking this action [enacting the McCarran-Ferguson Act] Congress must have had full knowledge of the nation-wide existence of state systems of regulation and taxation; of the fact that they differ greatly in the scope and character of the regulations imposed . . . Congress intended to declare, and in effect declared, that uniformity of regulation . . . are not required in reference to the business of insurance by the national public interest, except in the specific respects otherwise expressly provided for." (Prudential Ins. Co. v. Benjamin (1945) 328 U.S. 408 at 429-431.)

In enacting ERISA, Congress demonstrated that the need for state supremacy in insurance matters, and Congress' tolerance of disuniformity in the regulation of insurance, outweighed Congress' desire to provide uniform regulation of insurers that provided insurance benefits through ERISA plans. This conclusion is especially compelling since the legislative history of ERISA reveals that Congress never considered an insurance policy purchased by a plan to be the functional equivalent of the

plan itself.[4]

D. AS THE COURT OF APPEAL OBSERVED, "IN LIGHT OF THE BROAD HOLDING OF PILOT LIFE, . . . THE QUESTION OF WHETHER THE POLICY HERE IS GOVERNED BY ERISA TAKES ON VITAL IMPORTANCE . . . ." — A QUESTION WHICH HAS NEVER BEFORE BEEN ANSWERED BY THIS COURT.

1. The Intolerable Inconsistency of Existing Authorities.

One of the most popular and pervasive methods of selling health and disability insurance in the United States today involves group policies sold through employers or employer groups. If such

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[4]The ERISA oversight task force on Welfare and Pension plans noted: "They [multi-employer trusts] are no more ERISA plans than is any other insurance policy sold to an employee benefit plan." (H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1976), often referred to as The Activity Report of the Committee on Education and Labor.) While not contemporaneous legislative history, such reports are "'virtually conclusive' as to legislative intent. Sioux Tribe v. United States, 316 U.S. 317, 319 . . . ." (Bell v. Employee Sec. Ben. Ass'n. (Kan. 1977) 437 F.Supp. 382, 393.)

marketing strategies are broadly declared to be ERISA plans, then not only will the criminal sanctions and administrative burden of ERISA proliferate in a manner unforeseen by Congress, but, when coupled with the broad preemptive effect of Pilot Life, supra, insureds will be stripped of all state-imposed protections and remedies with no corresponding federal regulation of insurance or insurers. ERISA, instead of providing "employees" with "security" as its title implies, will, ironically, provide the ultimate immunity which insurers have unsuccessfully sought from state and federal legislatures.

In rejecting the approach adopted by the Court of Appeal below and finding that the mere payment of premiums for employee health insurance is not sufficient to constitute an ERISA plan, the California

Court of Appeal noted that, otherwise, "every garden-variety employee health insurance benefit would subject the paying employer, large or small, to ERISA's regulatory burdens, and would bind the insured to ERISA's remedies." Sayble v. Blue Cross of Southern California, —— Cal.App.3d ——, 255 Cal.Rptr. 144 (Feb. 2, 1989).

Unfortunately, now that the importance of the issue of what constitutes an ERISA plan has been explosively magnified by Pilot Life, the existing authorities provide nothing which even remotely resembles a uniform approach. The Seventh Circuit believes that intent is the touchstone of an ERISA plan. Wayne Chemical v. Columbus Agency Services Corp., 567 F.2d 692 (7th Cir. 1977). The California Court of Appeal, in Rizzi v. Blue Cross of Southern California (1988) 206 Cal.App.3d 380, 253

Cal.Rptr. 541, questions this approach, while the Eleventh Circuit rejects it outright. Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982). The Eleventh Circuit test, adopted in Donovan, supra, is whether, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." (688 F.2d at p. 1373). Under Donovan, the "bare purchase of health insurance" is evidence of an ERISA plan (id.). Yet, the Fifth Circuit held that the purchase of insurance is not a plan. Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208 (5th Cir. 1980), cert. den., *sub nom.*, Taggart Corp. v. Efros, 450 U.S. 1030, 101 S.Ct. 1739 (1981).

A different panel of the Ninth Circuit finds ERISA inapplicable if the employer group consists of "heterogeneous, unrelated employers." Credit Managers Assn. v. Kennesaw Life & Acc. Ins., 809 F.2d 617, 625, (9th Cir. 1987) (accord, Rizzi, supra). Here, the absence of such evidence did not prevent the application of ERISA.

Numerous courts have held that an employer association is not an "ERISA employer" under 29 U.S.C. § 1002(5), unless the evidence establishes that the individual employer played a part in the management of the employer association. See, e.g., Matthew 25 Ministries, Inc. v. Corcoran, 771 F.2d 21 (2d Cir. 1985); Donovan v. Dillingham, supra, at 1373; Hamberlin v. VIP Ins. Trust, 434 F.Supp. 1196, 1198 (D. Ariz. 1977); Baucom v. Pilot Life Ins.

Co., 674 F.Supp. 1175, 1181 (M.D. N.C. 1987); and Insurance & Prepaid Benefits Trusts v. Marshall, 90 F.R.D. 703 (C.D. Cal. 1981). The Court of Appeal below required no such evidence in order to find a plan.

The Court of Appeal below adopted and rigidified the four Department of Labor criteria as a bright-line test for determining the existence of a plan (29 C.F.R. § 2510.3-1(j) (1987) such that "any one of which would prevent the exclusion of the insurance plan from ERISA coverage (Appendix to Petition, p. D-89). Other authorities have either found ERISA inapplicable notwithstanding the absence of one or more criteria, or have contained dicta to that effect. See, e.g., Rizzi v. Blue Cross, supra; Sayble v. Blue Cross, supra; Donovan v. Dillingham, supra; Local Union

2134 UMW of America v. Powhatter Fuel (N.D. Ala. 1986) 640 F.Supp. 731, 734-735, vacated on other grounds in Local Union 2134, UMW of America v. Powhatter Fuel (11th Cir. 1987) 828 F.2d 710; and Credit Managers Assn. v. Kennesaw Life & Acc. Ins., supra, 809 F.2d at 625 (dicta).

2. The Definition Of An ERISA Plan Should Be Consistent With The Remedial Goals Of ERISA.

Amicus believes that the purposive analysis, as set forth in Rizzi, supra, and Sayble, supra, most closely and efficiently effectuates the intention of Congress in imposing uniform federal regulation. Under such an analysis, the existence of an ERISA plan depends on the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA (i.e., a potential for employer abuses such

as self-dealing, imprudent investing, and misappropriation of plan funds).

Nevertheless, whether this Court determines such an approach to be the "correct" one or not, this is an issue which must be decided and clarified as, in the wake of Pilot Life, the focus of national litigation regarding the state regulation of insurance which arguably is subject to ERISA, has shifted from the issue of preemption to the issue of what is an ERISA plan. As cogently understated in Rizzi v. Blue Cross, supra, the various "analytical approaches" the courts have considered "do not always coincide" (206 Cal.App.3d at p. 389, 253 Cal.Rptr. at p. 547).

CONCLUSION

The following conclusion appears to be inescapable: California Insurance Code §§ 790 et seq. were specifically enacted as a law regulating insurance under the McCarran-Ferguson Act which was sponsored by the NAIC which also sponsored the Model Unfair Claims Practices Law, and which act is, under Pilot Life, used to analyze whether a particular state law can be said to "regulate insurance" under the saving of ERISA. In other words, a brief look back into history and a simple reading of § 790 itself reveals that § 790 et seq. was not only a law regulating insurance, but was the very prototype of such a law.

In SEC v. National Securities, Inc. (1969) 393 U.S. 453, 89 S.Ct., 546, 21 L.Ed. 668, the Supreme Court stated as follows:

"The McCarran-Ferguson Act was an

> attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulations."

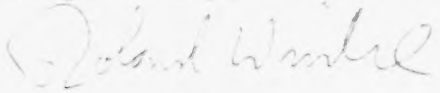
The Mississippi common law of bad faith in Pilot Life is a law of general application. The Massachusetts mandated-benefits law in Metropolitan Life and the California Unfair Claims Practices Act are laws "regulating insurance" directed exclusively toward the "business of insurance." The former is not saved from preemption. The latter is.

Moreover, and perhaps more important, if the broad preemptive force of ERISA threatens the sanctity of state regulation of the insurance industry in which principles of the McCarran-Ferguson Act, such an undesired and intrusive impact can be at least minimized by a definitive definition from this Court as to the existence

of an ERISA plan which provides insurance.

Dated: May 16, 1989.

Respectfully submitted,



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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,
Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,
Respondent.

AMICUS CURIAE BRIEF IN SUPPORT OF PETITIONERS (PURSUANT TO CONSENT OF THE PARTIES)

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No. 88-1659

IN THE
SUPREME COURT
OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS THEODORE KANNE AND BEATRIZ KANNE

INTRODUCTORY STATEMENT

Pursuant to the consent of the parties, copy of which is annexed hereto as Appendix "A," the undersigned Amicus Curiae, the California Medical Association, respectfully submits this

Brief in support of Petitioners, Theodore and Beatriz Kanne. [1] The undersigned is concerned with the present case because ERISA preemption threatens the welfare of the patients of its members. As will be detailed below (Point I, infra), the State of California has enacted numerous laws aimed at protecting

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1. The undersigned has previously moved this Court for leave to file an Amicus Curiae Brief in Juliano v. Commercial Life Ins. Co., No. 88-1530. The same considerations set forth therein apply to the instant case.

Additionally, however, the instant case presents an issue not presented in Commercial Life: the issue of what are the criteria which will establish that an insurance arrangement is an "employee benefit plan" subject to the Employee Retirement Security Act (ERISA) under 29 U.S.C. Section 1003, and related issues (see Questions Presented in the Kannes' Petition for Writ of Certiorari in the instant case at pp. i-iv).

The common issue in Commercial Life and the instant case is the issue of whether ERISA bars plaintiffs from securing state law remedies afforded by a state law which regulates insurance, specifically, California Insurance Code Section 790.03(h)(2).

and regulating health care. We believe that it is absolutely essential to the welfare of our patients that these laws remain in full force and effect. Their enforceability and effectiveness should not be diluted or delayed by questions concerning whether the federal law of ERISA may impact upon them in some manner.

ARGUMENT

I

IT WAS NOT THE INTENTION OF CONGRESS TO DESTROY THE SAFEGUARDS AND PROTECTIONS AFFORDED BY STATE LAW FOR THE BENEFIT OF THE VERY PERSONS CONGRESS INTENDED TO PROTECT BY ENACTING ERISA.

ERISA was not enacted in order that the federal government regulate the payment of insurance claims and other health benefits. It is not designed to police the prompt payment of legitimate

insurance claims, and did not even contemplate this problem.

Thus, ERISA permits insurers to delay or deny claims with impunity. Under ERISA, an insurer who wrongfully denies payment of a claim is required only to pay what the insurance policy required it to pay in the first place and attorneys' fees in the discretion of the Court. 29 U.S.C. Section 1132(g). And there is no requirement at all that claims be paid promptly. Under ERISA regulations, an insurance company may delay any decision as to whether to pay a claim for up to 300 days. 29 CFR Section 2560.503-1(e)(1)(3); Section 2560.503-1(h). Even if an insurer in fact violates this 10-month provision, it is not subject to any penalties, even the ineffective ERISA penalties. Insofar as we are aware, there is no provision in

the statute or the regulations requiring prompt payment of a claim even if it is not denied or contested. See 29 U.S.C. Section 1132; 29 CFR Section 2560.503-1.

We do not believe that the health care system in California can withstand a great number of delays in payment for such inordinate lengths of time, even if payment is ultimately made. [2] Because of the large number of employees in California dependent on ERISA employee benefit plans to pay their bills, the potentially catastrophic effect of ERISA preemption is self-evident, and cannot

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2. The type of abuses that are threatened is demonstrated by the facts of the instant case. See petitioners' petition at pp. 5-12, opinion of the District Court, Kanne v. Connecticut General Life Ins. Co., 607 F.Supp. 899 (C.D. Cal. 1985).

seriously be denied. [3]

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3. The primary mechanism for enforcing the prompt payment of legitimate claims in California has been the private right of action for breach of the California Insurance Unfair Claims Practices Act, Ins. C. Section 790.03(h). The California Supreme Court has now prospectively abolished this private right of action. Moradi-Shalal v. Firemen's Fund Ins. Cos., 46 Cal. 3d 287, 758 P.2d 58 (1988). However, the California Supreme Court made it clear that the Legislature has the power to reinstate the private right of action. Moradi-Shalal, supra, 46 Cal. 3d at p. 305, 758 P.2d at p. 69.

The opinion of the Ninth Circuit Court of Appeals in the present case holds that ERISA preempts such private rights of action. Hence, if permitted to stand, the present opinion will bar the State of California (and, of course, the 49 other states as well) from ever authorizing a private right of action which can be asserted against insurers of ERISA plans. This will drastically limit the traditional power of the states to curb claims abuses through private rights of action--the most effective method of doing so.

Whether ERISA preemption will affect the states' ability to curb such abuses through criminal and administrative action is an open question not ruled upon by the Ninth Circuit in the present case. See Appendix to Petition, Appendix D at p. D-80.

Nor is our concern over ERISA preemption addressed solely to California Insurance Code Section 790.03(h), the statute at issue in the present case. Numerous other beneficial and protective California laws regulating insurance and other health care services are also threatened by a broad interpretation of ERISA preemption. Some of these laws include the following:

1. Provisions prohibiting insurers from discriminating between individuals because of race, color, religion, national origin or ancestry. California Insurance Code Sections 10140, 10141;

2. Provisions prohibiting less favorable terms to employees in group disability insurance plans than to their spouses. California Insurance Code Section 10122.2. See also California Insurance Code Section 10123.4; Health

and Safety Code Section 1374;

3. Provisions prohibiting discrimination against physically handicapped persons. California Insurance Code Sections 10123.1, 10123.2; Health and Safety Code Section 1373(f);

4. Provisions prohibiting discrimination against persons carrying a gene which causes no adverse effects in the carrier. California Insurance Code Sections 10123.3, 10143, 11512.95; Health and Safety Code Section 1374.7;

5. Provisions barring exclusion of victims of Alzheimer disease or other dementing illnesses from receiving benefits or other coverage. California Insurance Code Sections 10123.16, 10123.17, 11512.177; Health and Safety Code Section 1373.14;

6. Provisions barring group disability insurers and health care

service plans from discriminating against the blind. California Insurance Code Section 10145; Health and Safety Code Section 1367.4;

7. Provisions preventing insurers from controlling the patient's selection of a hospital or physician. California Insurance Code Section 10133;

8. Provisions that health care service plans and hospital service plans which affect a patient's freedom of choice in selecting physicians or hospitals must clearly so inform the patient. California Insurance Code Sections 10123.12, 11512.176; Health and Safety Code Section 1367.10;

9. Provisions requiring health care service plans (which restrict the patient's freedom of choice of providers) to follow a variety of procedures to insure access to quality medical care.

Health and Safety Code Sections 1368, 1369, 1370; 10 Cal.Admin. Code Sections 1300.6, 1300.68, 1300.70;

10. Provisions requiring that facilities providing the primary health care services of a health care service plan must be located within reasonable proximity of the business or personal residences of enrollees, that the hours of operation and provisions for after-hour services must be reasonable and that emergency health care services must be available and accessible within the service area 24 hours a day, seven days a week. 10 Cal.Amin. Code Section 1300.67.2;

11. Numerous provisions mandating that entities providing coverage for health care provide certain benefits, as well as coverage for dependents of the insured or plan participant. Some

examples of mandates include the following:

a. Requirements that coverage continue for certain dependents upon the attainment of the limiting age for dependency. California Insurance Code Sections 10277, 10278, 10124; Health and Safety Code Section 1374;

b. Requirements of coverage for newborn infants or newly adopted children. California Insurance Code Sections 10119, 10121(b), 11512.1; Health and Safety Code Section 1373;

c. Coverage requirements for maternity benefits. California Insurance Code Section 10119.5, 10121(c), 11512.13; Health and Safety Code Section 1373.4;

d. Coverage for conditions attributable to diethylstibestrol or exposure to it. California Insurance Code Sections 10119.7, 11512.195; Health

and Safety Code Section 1367.9;

e. Coverage requirements for diabetic daycare self-management education programs. California Insurance Code Sections 10177.7, 11512.23; Health and Safety Code Section 1367.5;

f. Coverage requirements for home health care. California Insurance Code Section 11512.20; Health and Safety Code Section 1374.10;

g. Coverage requirements for mental or nervous disorders. California Insurance Code Sections 10125, 10127, 11512.5; Health and Safety Code Section 1373(h);

12. Provisions requiring that coverage must be extended 12 months after discontinuance of a plan or policy for expenses relating to any condition causing total disability. California Insurance Code Sections 10128, 10128.2;

Health and Safety Code Section 1399.62;

13. Provisions to insure that providers of health coverage extend coverage following the termination of the employment of an employee. California Insurance Code Sections 10122, 10123, 11512.1; Health and Safety Code Section 1373;

14. A provision prohibiting a policy of insurance or health plan providing for loss of time benefits to contain any provision for a reduction of those benefits during a benefit period because of an increase in benefits payable under the Federal Social Security Act. California Insurance Code Section 10127.1; Health and Safety Code Section 1373;

15. Perhaps most importantly, California law requires reimbursement of covered expenses no later than 30 days

after receipt of the claim, unless a claim or portion thereof is contested. California Insurance Code Sections 10123.13, 11512.180; Health and Safety Code Section 1371.

The foregoing constitute only some of the laws of California aimed at protecting those California citizens who may have medical problems requiring the services of physicians and hospitals. We respectfully submit that Congress had no intention whatever of permitting the provisions of ERISA to nullify any of the foregoing statutes. It is clear that ERISA was established for the primary purpose of safeguarding employee pension plans, and was addressed to the problem that many pension plans relied on by employees for retirement income were rendered insecure and illusory by various questionable practices by the people

administering the plans. See, e.g.: Massachusetts v. Morash, ____ S.Ct. ____ (No. 88-32) (filed April 18, 1989); California Hospital Ass'n v. Henning, 770 F.2d 856, 859 (9th Cir. 1985), mod., 783 F.2d 946 (1986), cert. den., 477 U.S. 904 (1986). This purpose had nothing whatever to do with the issue of enforcement of fair claims practices or of the other laws set forth above. Nor is there anything in the Congressional findings and declarations of policy even remotely reflecting a Congressional intention to preempt state laws aimed at protecting beneficiaries of medical, hospital or disability insurance contracts, or state laws otherwise protecting the sick and disabled. To the contrary, the statute plainly and explicitly states that the "well-being and security of millions of employees and

their dependents" is the primary purpose of ERISA. 29 U.S.C. Section 1001, subdivision a. See also 29 U.S.C. Section 1001a, subdivision (a) (3) and 29 U.S.C. Section 1001b, subdivision (a) (2). This purpose would clearly be defeated by permitting ERISA preemption to prevent the States from affording state remedies to the very persons ERISA was designed to protect.

II

THIS COURT SHOULD RESOLVE THE ISSUE OF THE CIRCUMSTANCES WHEN AN INSURANCE ARRANGEMENT IS A PLAN GOVERNED BY ERISA.

We respectfully submit that an insurance arrangement which is not part of a written plan purposefully established as an ERISA plan should not be considered an ERISA plan. In Massachusetts v. Morash, supra, this Court held that an arrangement for

vacation benefits payable out of an employer's general assets did not constitute an ERISA plan. As noted above, this Court pointed out that Congress' primary concern in enacting ERISA was with the mismanagement of funds accumulated to finance employee benefits. This Court said that where a separate fund is not created to guarantee the payment of benefits the arrangement is not an ERISA plan. This Court also pointed out that extension of ERISA to claims for vacation benefits "would vastly expand the jurisdiction of the federal courts." This Court also noted that the states have "traditionally regulated" the payment of wages, including vacation pay.

Each of these elements are present in insurance arrangements such as the arrangement in the case at bar. The

insurance premiums are not paid out of a trust created for that purpose. To extend ERISA to claims for delay or denial of payments, or to other claims arising out of state laws addressed to health care, would vastly expand the jurisdiction of the federal courts. And the states have "traditionally regulated" insurance claims handling and other laws relating to health care. We therefore respectfully submit that the principles of Massachusetts v. Morash should apply to determinations of whether insurance arrangements are ERISA plans. But regardless of which criteria are utilized, we respectfully submit that it is urgent that uniform criteria, which are plain and unambiguous, should be adopted and the current conflicts among the various courts should be resolved.

Conclusion

We respectfully submit that the Kannes' petition should be granted.

Respectfully submitted,

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and
LOUIS G. FAZZI
Attorneys for Amicus Curiae
CALIFORNIA MEDICAL ASSOCIATION

APPENDIX A

No. 88-1659

IN THE
SUPREME COURT
OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPPEALS
FOR THE NINTH CIRCUIT

CONSENT TO FILING OF BRIEF AMICUS CURIAE
BY THE CALIFORNIA MEDICAL ASSOCIATION

We, Petitioners Theodore Kanne and Beatriz Kanne and Respondent Connecticut General Life Ins. Co., who are all the parties to the above-entitled cause, herein consent, by our respective counsel

of record, to the filing of a Brief of an Amicus Curiae by California Medical Association, in support of the Petition for Writ of Certiorari of Theodore and Beatriz Kanne, Petitioners, pursuant to Rule 36 of the Supreme Court rules.

CONNECTICUT GENERAL LIFE INS. CO.

By: Theodore B Olson

DATED: May 15th, 1989.

THEODORE KANNE and BEATRIZ KANNE

By: Leonard Kaden

DATED: May 10, 1989.

(5)

No. 88-1659

Supreme Court, U.S.
FILED
MAY 31 1989
JOSEPH F. SPANIOL, JR.
CLERK

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

AMICUS CURIAE BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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Amicus Curiae

QUESTION PRESENTED

1. What are the criteria which establish that an insurance arrangement is an "employee benefit plan" subject to ERISA, under 29 U.S.C. Section 1003, where, as here, there is no formal written plan?[1/]

[1/] It is safe to predict that there will eventually be numerous other petitions filed in this Court raising this issue, in view of the uncertainty surrounding the issue of the circumstances under wich an insurance arrangement constitutes an "employee benefit plan" subject to ERISA. In the instant matter, the insured's direct employer had not established or maintained an employee benefit plan subject to ERISA as defined by 29 U.S.C. Section 1003(a). Such a plan is not established by the activities of a "group or association of employers," pursuant to 29 U.S.C. Section 1002(5), where there is no evidence that the purported employer association in question was, in fact, a group or association of homogeneous, related employers, and no evidence that the insured's direct employer had any voice in the management of the purported employer association in question.

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No. 88-1659

IN THE SUPREME COURT
OF THE UNITED STATES
October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

AMICUS CURIAE BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Amicus Curiae respectfully petitions this Court for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

A. OPINIONS BELOW, JURISDICTION, STATUTES AND REGULATIONS INVOVED IN THIS CASE, STATEMENT OF THIS CASE

Amicus Curiae respectfully refers the Court to the petition of petitioners Theodore Kanne and Beatriz Kanne.

I.

DETERMINATION OF THE ELEMENTS NECESSARY TO ESTABLISH THAT AN INSURANCE ARRANGEMENT IS AN "EMPLOYEE BENEFIT PLAN" SUBJECT TO ERISA IS AN ISSUE OF WIDESPREAD IMPORTANCE UPON WHICH THIS COURT HAS NEVER RULED.

In the practice of the Amicus Curiae, it has been noted that insurers are baldly holding themselves out to be ERISA benefit plans and, are not complying, in any respect, with the statutory requirements of such plans.

The courts, and various federal agencies, have long been aware of insurers' desire to hold themselves out as ERISA benefit plans. They have so desired in order to escape the strict laws of the states in which they do business, and to avail themselves of the much less stringent ones provided by the ERISA enforcement scheme. The following is a quote of the 1977 pension task force which stated as follows:

> "It has come to our attention, through the good offices of the national association of State insurance Commissioners that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected,

under ERISA's peremption provision, from state regulation. We are concerned with this type of development, but on the basis of the facts before us, we are of the opinion that these programs are not 'employee benefit plans' as defined in section 3(3). As described to us, these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites of the act. They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan.

We are mindful of the potentially harmful effects of an overly broad interpretation of the term 'employee benefit plan' when coupled with policy of section 514 which is ERISA's preemption provision. As we have already noted, we do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the definition. Where a (plan) is, in effect, an entrepreneurial venture, it

> is outside the policy of section 514...insurance, to be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definitional requirements of section 3(3) in both form and substance."

It should be noted that this report was extensively quoted with approval in the following cases, Private Medical Care Foundation, Inc. v. Califano, at 451 F.Supp. 450, 461 (W.D. Okl. 1977) as well as Hamberlin v. VIP Insurance Trust, at 434 F.Supp. 1196, 1199 (D. Ariz. 1977; Bell v. Employee Sec. Benefit Ass'n, at 437 F.Supp. 382, 392 (D. Kan. 1977); National Business Conference v. Anderson, 451 F.Supp. 458, 461 (S.D. Iowa 1977); Wayne Chemical Inc. v. Columbus Agency Service Corporation, 567 F.2d at 692, 699 (7th Cir. 1977); and, Taggart Corp. v. Life and Health Admin., 617 F.2d at 1208, 1210 (5th Cir. 1980). The above courts mention that, although

the oversight report was not contemporaneous legislative history, it is "virtually inclusive" as to legislative intent. Sioux Tribe v. United States, at 316 U.S. 317, 319 (1942).

There is now great danger that an insurer may baldly hold itself out to be an ERISA benefit plan without substantially complying with the requirements of ERISA pursuant to 29 U.S.C. Section 1003(a). It appears to amicus curiae, based upon personal experience in his law practice in Los Angeles, California, that insurers are, in fact, not complying with the necessary criteria established by 29 U.S.C. Section 1003(a), yet are attempting to avail themselves of the protections afforded by the ERISA enforcement scheme. Such is the case in the within matter, where there is no written employee benefit plan, and no

evidence either that the employer had any intention whatsoever of establishing an employee benefit plan subject to ERISA, or that it made any attempt to comply with the various ERISA regulations governing such plans. As petitioner argues, this Court has never spoken on this particular issue. The case of Fort Halifax Packing Co. v. Coyne, ___ U.S. ___, 107 S.Ct. 2211 (1987) makes it clear that the provisions of ERISA do not apply unless a plan or program has been created. However, it does not address the issue of what elements are necessary to establish the existence of such a plan or program. Certainly, we must not allow insurers to avail themselves of ERISA protection merely by including one page in their benefits booklet calling themselves an ERISA benefit plan, without any further evidence demonstrating compliance

with ERISA requirements.

In order to be an "ERISA employer" under 29 U.S.C. Section 1002(5), an alleged employer group or association must be "a group or association of employers acting for an employer in such capacity." It has been held that an employer association is not an "ERISA employer" under this provision, unless the evidence establishes that the individual employer played a part in management of the employer association. If the employer association fails to show what role the individual employers played in its management, such employer is not covered by ERISA. See Matthew 25 Ministries, Inc. v. Corcoran, 771 F.2d 21 (2nd Cir. 1985); Donovan v. Dillingham, 688 F.2d 1367, FN 11 (11th Cir. 1982). See also Hamberlin v. VIP Ins. Trust, 434 F.Supp. 1196, 1198 (D. Ariz. 1977) (for an employer group to

be an ERISA plan, the employers must have a voice in its management); Baucom v. Pilot Life Ins. Co., 674 F.Supp. 1175, 1181 (M.D. N.C. 1987) (same); Insurance & Prepaid Benefits Trusts v. Marshall, 90 FRD 703 (C.D. Cal. 1981) (an employer group can qualify as an ERISA plan only when such group involves an association of employers, the employers participate in the benefit committee and that committee makes final decisions). See also, Rizzi v. Blue Cross of So. Cal., 206 Cal.App.3d 380, 253 Cal. Rptr. 541 (1988).

Moreover, where an employer group consists of "heterogenous, unrelated employers," ERISA is inapplicable. Credit Managers Ass'n v. Kennesaw Life & Acc. Ins., 809 F.2d 617, 625 (9th Cir. 1987). In the Rizzi case, supra, the California Court of Appeal specifically questioned the instant

Kanne decision because of this rule (206 Cal.App.3d at p. 386, FN 4, 253 Cal.Rptr. at p. 544, FN 4).

Review of this matter is required because the Court of Appeals' holding in the instant case is directly contrary to all of the above authorities. There is no evidence that the employer in this instant case (or, for that matter, any other employer), played any part in the management of ABC, the purported "ERISA employer," and no evidence that ABC was a group of homogeneous, related employers.

Should such a ruling be allowed to stand, it is likely to create precisely the situation which the 1977 Pension Task Force feared when it wrote the cautionary material cited hereinabove, supra.

Further, petitioner addresses the very important question of whether the

"bare purchases of health insurance" may constitute a "plan" subject to ERISA. Taggart Corp. v. Life & Health Benefits Admin., supra, 617 F.2d 1208, 1211, held that there is no ERISA plan under these circumstances. Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) holds that "bare purchases of health insurance" is evidence of an employee benefit plan governed by ERISA and the issue is one of fact to be decided on a case by case basis (688 F.2d at p. 1373). Donovan specifically disapproves the holding of Taggart Corp., supra, on this subject. (688 F.2d at p. 1375).

In Rizzi v. Blue Cross of So. Cal., supra, the California Court of Appeal noted the confusion and inconsistency among the authorities (206 Cal.App.3d at pp. 384-388, 253 Cal.Rptr. at pp. 543-546), stating that

the various "analytical approaches" the Courts have considered "do not always coincide" (206 Cal.App.3d at p. 389, 253 Cal.Rptr. at p. 547). Therefore, amicus curiae respectfully asserts that clarification in this area is urgently needed and is, as petitioner points out, utterly lacking. For this reason, it is vital that the United States Supreme Court issue a definitive pronouncement of the criteria for determining the existence of an employee benefit plan governed by ERISA under 29 U.S.C. Section 1003(a). Amicus curiae respectfully suggests that this Court adopt stringent criteria, but criteria which may be easily understood and applied.

In order for an insurer to escape stringent state regulation in favor of the relatively minor civil penalties provided

by the ERISA enforcement scheme, it should have fully complied with all of the criteria provided under 29 U.S.C. Section 1003(a).

Further, since, as petitioner points out, there are criminal sanctions which may be imposed upon employers for failure to comply with ERISA requirements under 29 U.S.C. Section 1131, it is additionally advisable that this Court adopt criteria which may be easily understood and applied, since a criminal statute must certainly be plain and unambiguous.

With all the confusion in the current authorities, there is simply no way of knowing with any certainty when ERISA is applicable, and when the duty of compliance with ERISA regulations arises.

In order to avoid future confusion and uncertainty, and resultant chaos in

the State and Federal Court systems, it is necessary that guidance on this subject be provided by the Supreme Court.

CONCLUSION

It is urgently necessary that the State and Federal courts be afforded specific guidance with respect to when the Federal law embodied in ERISA applies to medical and disability insurance arrangements where no written employee benefit plan exists. At the present time, the law practice of amicus curiae is replete with examples of confusion and uncertainty concerning the within issue. All sides to this controversy agree that an authoritative pronouncement from this Honorable Court is necessary to prevent further spread of this deeply troubling confusion and uncertainty.

Respectfully submitted,
STEVEN P. GOLDBERG
Amicus Curiae